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STATUS OF VETERANS' HEALTH CARE IN FLORIDA

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 23, 1989
ORLANDO, FL

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STATUS OF VETERANS' HEALTH CARE IN FLORIDA

THURSDAY, MARCH 23, 1989

U.S. Senate,
Committee on Veterans' Affairs,
Orlando, FL.

The committee met, pursuant to notice, at 10 a.m., at the Orlando Museum of Art, 2416 N. Mills, Orlando, FL, Hon. Bob Graham (acting chairman of the committee) presiding.

Present: Senator Graham.

OPENING STATEMENT OF SENATOR GRAHAM

Senator **Graham**. This field hearing of the Senate Committee on Veterans' Affairs is called to order. I ask everyone to rise for the Pledge of Allegiance.

[The Pledge of Allegiance was given.]

Senator **Graham**. Thank you very much. I appreciate starting out our hearing in such an appropriate manner.

I would like to welcome each of you who has come to this hearing today, which I think you will find a very thoughtful and informative one, one which will hopefully help us identify the areas of greatest need and a direction for the Senate Veterans' Affairs Committee.

Today's meeting has been convened specifically to investigate the issue of veterans' health care. I know that there will be other issues that many of you might like to bring to the attention of the committee or to our office. There will be cards distributed on which you can indicate any questions or comments that you might have. They will be collected and each of those will be individually responded to.

On the specific issues of veterans' health care, there is no more appropriate place in which to carry out a field hearing than here in Florida. Before we begin, I would like to take this opportunity to thank our distinguished panel members who will be joining us today, and for their work in preparing for this hearing. I also want to thank all of you who have made the personal effort to come here to observe this hearing, and hope that you will come away finding it interesting, enlightening and valuable.

Our topics, veterans' health care accessibility, and the Department of Veterans Affairs medical care budget shortfall, are very important to Floridians. Many of you know best, from your personal experience, what the effects of the shrinking pool of VA funds have been on veterans. Florida veterans, perhaps more than any other veteran population in America, can speak to the problems caused by insufficient funding. Today you will hear from Floridians who are veterans, veterans' representatives, veterans' advocates, or Department of Veterans Affairs officials. At the close of this hearing we should have a strong, permanent record of the current state of veterans' health care in Florida, which the Senate Veterans' Affairs Committee will use to help find the needs of America's veterans.

We are faced with what is conservatively estimated to be a $635 million shortfall in the Department of Veterans Affairs medical care account for the fiscal year 1989. The VA has come to a critical point in its existence. The shortfall has called into question the ability of the VA to accurately and competently deliver health care to our veteran population. We are sacrificing the future to meet the needs of the present. This is a problem.

I and 40 other Senators wrote to President Bush requesting his support for adequate funds to support the VA health care for the fiscal year 1989. And on March 6 at the budget hearing of the Veterans' Affairs Committee, we asked the President to recommend a supplemental budget of $618 million for the balance of this fiscal year. The Secretary of Veterans Affairs has also requested funds for this purpose, although far less than the Senate's request. We hope that President Bush will act quickly and submit a request for additional funds for this fiscal year.

For the next fiscal year, for fiscal year 1990, the Senate Veterans' Affairs Committee recently voted to recommend an increase of $95 million to the present major construction fund budget. A vital item in the medical care budget, the major construction account, was, I believe, underfunded at the President's recommendation. The recommended increase by the Senate Veterans' Affairs Committee would allow us, among other things, to fund the project, which the VA listed as their No. 1 priority in its budget submission to the Office of Management and Budget, a 120-bed nursing home addition to the VA medical center in Lake City, FL. The Office of Management and Budget declined to take the VA's recommendation and struck the project from the President's budget. I think, the committee thinks, it needs to be restored.

Also on the VA's top priority list, but excluded from the President's budget, is funding for a long-term psychiatric center in Gainesville, FL. This project has been languishing for a decade. Continuing among the top priority projects for the VA, it too, always falls prey to the budget knife. It is hard to believe, but true, that Florida is the only medical district in the Veterans' Administration without any long-term psychiatric care beds. It is a need we've had ignored for too long, and I support allocating funding for its construction. Although the President did include funds for a medical center in Florida, the Palm Beach Medical Center, it's important that we follow the original design and construct a nursing home facility as part of that center.

Finally, the VA's long-term planning analysis calls for the placement of 100 spinal cord injury beds in Florida's medical district. Without further delay these beds need to be constructed and activated.

But construction is only one part of a complex medical care system budget that has taken repeated blows over the past few years. The new Department of Veterans Affairs, and its new Administrator, Secretary Derwinski, will need to prove themselves as true champions of America's veterans under very trying circumstances. We may receive additional funding for this fiscal year, but that would not solve the problems which veterans are going to face in the future. Too many veterans are being turned away from VA hospitals because they are in the wrong category. VA hospitals are experiencing shortages, shortages in manpower, particularly nurses, pharmacists, and other health care professionals. There is a tremendous backlog of equipment purchases because the Veterans' Administration medical centers have been forced to divert money from equipment purchases to pay personnel costs.

These are examples of how the budget shortfall has impacted on the VA's medical system. Today we will learn how Florida's veterans and Florida's VA hospitals have felt that impact, how they will deal with it, and what we need to do to correct its negative effects.

Again, I appreciate the cooperation of all of those who have helped make this hearing possible, particularly the witnesses. I look forward to hearing their testimony.

We have a statement which has been submitted by the ranking minority member of the committee, Senator Murkowski of Alaska, who expresses his regrets that he could not be with us today. He has asked that his statement be printed in the record, copies of it are available at the press table.

[The prepared statement of Senator Murkowski appears on p. 49.]

Senator **Graham**. We also have with us representatives of the staff of the Veterans' Affairs Committee, Miss Sandi Isaacson, professional staff; and Miss Lisa Moore, representative of the minority staff. From my office we have Miss Rena Coughlin, Miss Ann Hardison, Charlie Yonts, the Director of Veterans' Affairs in our field office in Tallahassee; Ronnie Schlicte, who is the director of our central Florida office from Tampa; Michael Suarez, and Lauriean Ciccarelli.

The rules of the Senate Veterans' Affairs Committee require that all witnesses be sworn prior to their testimony. In order to facilitate the hearing, I would ask that all of those who will testify today, please stand and take the oath.

[Witnesses sworn.]

Mr. **Thrall**. Excuse me, sir

Senator **Graham**. Yes, sir.

Mr. **Thrall**. Before you begin, sir, I'd like to establish two points. Are any of us who came to attend this meeting going to be allowed to offer information?

Senator **Graham**. If we have time at the conclusion of the panels, we will have a short period for other persons to make their statements. We are submitting cards and asking for anyone who has other information or questions that they would like to provide, to do so and you will be contacted individually.

Mr. **Thrall**. And the second point, sir, if I may, many of us have been aware of recent reprisals of whistleblowers. Suicide rates are very high, marriages break up, they're destitute financially. Can you do anything, before this meeting begins, to assure us that if we do, in effect, blow the whistle on inadequate systems within the VA medical delivery system, that you support our efforts and make sure our actions don't result——

Senator GRAHAM. We have asked all people who are going to testify today to take an oath that they're going to tell the truth, the whole truth, and nothing but the truth. We expect that, and we will protect that truth.

Mr. THRALL. Thank you. [Applause.]

Senator GRAHAM. Before we start, I have some other persons I would like to recognize. First, representing Mayor Frederick's office, is Miss Mary Johnson, city commissioner. From Congressman Bill McCollum's office, we have John Ariole, district representative; Elaine Wimple, staff assistant; intern, Lisa Ashley; and Christen Fox. Congressman Tom Lewis has asked me to announce that he had hoped to be here today, and regrets his inability to attend.

Our first panel today consists of two Floridians who have important positions in State government, relative to Florida's veterans. First, Hon. Alzo Reddick, State representative, who is chairman of the Florida House Committee on Emergency Preparedness, Military and Veterans' Affairs. Representative Reddick served in the Army, active duty in Germany prior to becoming an administrator of the Valencia Community College. He was elected to the house in 1982. He has been especially involved in educational issues, as well as involved with Florida's veterans.

The second member of the panel is Gen. Earl G. Peck, executive director, Florida Department of Veterans Affairs. General Peck served in the military for 36 years, and has an MBA from George Washington University. He previously served as the director of the Florida office for Veterans Affairs, and was appointed director of the newly created department, effective February 16, 1989. He has numerous decorations for his service and teaches graduate level classes in personnel management.

I will call on Representative Reddick first, and under the committee rules, each speaker is limited to 5 minutes. If your statement exceeds that, it can be submitted and will be printed in full in the record.

And then General Peck, after which time I will have questions.

TESTIMONY OF HON. ALZO J. REDDICK, STATE REPRESENTATIVE AND CHAIRMAN, COMMITTEE ON EMERGENCY PREPAREDNESS, MILITARY AND VETERANS AFFAIRS, FLORIDA HOUSE OF REPRESENTATIVES

Mr. REDDICK. Senator Graham, fellow Floridians, good morning and thank you for the opportunity to share with you this morning.

As chairman of the Florida House of Representative's Emergency Preparedness, Military and Veterans Affairs Committee, I feel compelled to share my thoughts regarding what I consider the Federal Government's inequitable treatment of veterans in Florida. As you know, Florida has the distinct honor of having the fastest growing veteran population among large States in the Nation, totaling approximately 1.5 million. During the decade of the 1970's, Florida's population of military veterans increased by 43.3 percent, the largest such increase in the Nation. This mammoth growth has sustained throughout the 1980's, and is expected to continue until the end of the century.

In addition to experiencing a bigger surge in veteran population growth than any other large State, we have a number of other States that are losing veteran-backed contracts. Certain demographics of the Florida veterans population are of particular significance and concern for this gallery to date. Florida is home to the oldest median age veteran population in the Nation. Florida has both the highest incidence of service-connected disabled veterans, and the most seriously disabled veteran population in the United States. Much of this is attributed to our inordinately large proportion of World War I and World War II veterans, coupled with the fact that Florida is home to both the fourth largest population of Korean and Vietnam era veterans, as well.

In view of Florida's obvious bulging veteran population, and its resulting deficits, the Federal Government, principally the VA, has been extremely slow to react appropriately. For example, with its extremely high percentage of disabled veterans, over 12 percent of the total veteran population, and the highest level of average disability rating, Florida is also the location where VA health care is least, underline, emphasis, paren, least available. Although Federal expenditures on Florida veterans and their dependents total well over $3 billion annually, and over $2 billion in VA guaranteed home loans, more veterans are denied VA health care in Florida than anywhere else in the Nation.

If only average access was provided to VA health care in Florida, the Commission on Veterans' Affairs estimates that additional care received would be worth approximately $160 million per year. To put it another way, while veterans are consistently moving to Florida from other States across the Nation, health care dollars appropriated by Congress are not following them. For reasons beyond my ability to comprehend, the money continues to go to the States where veterans are leaving. If the money was following the veterans as it logically should, we would automatically be entitled to a much more significant piece of the pie for our veteran population, to the tune of at least $160 million.

I sincerely feel the provision of adequate health care services to Florida's veterans is not only the right thing to do, it is the cost effective, and the economically sound thing to do.

I want to skip over part of my testimony and simply summarize. The VA regional hospital in St. Petersburg is a prime example. This regional office is a centralized processing point of all applications for VA benefits. While Florida has emerged as the only large State with rapid growth in its veteran population, it also has experienced one of the most pronounced reductions in terms of VA workers—manpower shortages arguably have numerous implications. Florida has the busiest veterans' regional office in the Nation in terms of applications processed per worker. Florida has the largest number of claims denied. Appeals to the Veterans' Appeals Board are twice as numerous.

Senator, and fellow Floridians, I have another 6 pages and another 3 minutes to go, but I think that the evidence of these statistics speak for themselves, and in conclusion, Senator, I would simply urge and request your continued attention and surveillance over these activities until such time as we can address these extremely significant problems in our State and do both the economically sound thing to do, and repay the debt that we owe our veterans.

And with that, I thank you, sir, for your attention. [Applause.]

[The prepared statement of Mr. Reddick appears on p. 51.]

Senator **GRAHAM**. Thank you very much, Representative Reddick.

And next we'll hear from General Peck.

TESTIMONY OF MAJ. GEN. EARL G. PECK, USAF (RET.), EXECUTIVE DIRECTOR, FLORIDA DEPARTMENT OF VETERANS AFFAIRS

General **PECK**. Thank you, Senator Graham, for the opportunity to be here this morning. I have submitted extensive written testimony. I won't repeat any of that here this morning. I would associate myself to the substance of remarks by Representative Reddick, and I applaud the substance in your opening statement, Senator Graham, with regard to help which may be forthcoming.

I would simply like to generalize for a couple of minutes. The veterans of the United States perceive that their entitlements, benefits, and services are gradually and continuously being eroded. That perception is borne out by the reality of insufficient budgets, budget shortfalls, over the past few years. That problem for the veteran population of the United States is compounded in Florida, geometrically, by the facts stated by Representative Reddick, that Florida has the fastest growing veteran population in the United States.

You may ascribe the shortfall in Florida simply to bureaucratic inertia or even perhaps impure motivation, but the fact of the matter is the Florida veteran suffers more than any other veteran in the United States from inadequate health care. No matter what you attribute that to, a large part of that responsibility, sir, must be borne by the U.S. Congress. When the VA makes an effort to close or downgrade a medical facility in Washington, in order to divert resources elsewhere, it is flocked by congressional action. If the VA attempts to suggest consolidating insurance offices in St. Paul and Philadelphia, it is blocked by the representatives from those two States. In short, the VA is severely constrained and hamstrung with regard to its ability to reallocate resources consistently with the reassignment of population. And I submit that the Congress would start with itself in this process because the people of Florida suffer more than anyone else in this problem.

There are ramifications beyond the simple medical shortfalls today, which are troublesome. The Federal Government has encouraged States to embark on State home programs over the years, and they've been mutually beneficial, because the Federal Government funds 65 percent of the construction costs and pays a per diem allowance thereafter. In most States those facilities are assisted by VA carrying arrangements or purchasing agreements which make it even more attractive for the States. The resource shortfall, from which the VA suffers, will make this less and less possible, and may make State homes subsidized by the Federal Government less attractive to States in the future.

I'd be happy to answer your questions, Senator. Thank you very much.

[The prepared statement of General Peck appears on p. 63.]

Senator **GRAHAM**. Thank you very much, sir. [Applause.]

Representative Reddick, could you review for us what you see as the priority items for your committee this year, specifically within the category of health care, as the major needs for Florida veterans?

Mr. **REDDICK**. Thank you very much, Senator.

First of all we want to see the speedy completion of the domiciliary and Lake City, and we'd like to move very quickly on the issue of additional nursing home and a series of priorities that have been developed by the Veterans Planning Group. The Veterans Planning Group's priorities, and the priorities of the Veterans' Affairs Committee, are virtually identical and they are all listed there for you.

Senator **GRAHAM**. Thank you, Representative Reddick.

General Peck, you mentioned in your testimony that Florida will be significantly impacted by the aging of population. What specific needs do you see arising as the population ages, and what do you anticipate will be the pace. What is the Department doing to anticipate and plan for this trend in Florida's veteran population?

General **PECK**. I have encouraged the legislators in Tallahassee to assist us in the process of embarking on a program for State nursing homes for veterans. I've alluded to the fact that the Federal Government subsidizes that process, and I think it can continue to be mutually beneficial. The Veterans' Administration will provide its share of nursing facilities, with the help of the Congress in association with the VA medical centers, both existing and planned, and I believe the States can absorb a share of that responsibility.

Florida will have a problem with its general population, whether veteran or not with regard to aging. And I believe that it's prudent and economic for the State of Florida to attack that problem through the veteran population because of the Federal subsidy in construction, and Federal subsidy in operation through the per diem arrangement. In fact some States have reached a point where through copayments and per diem, and the original subsidy, they've reduced the cost of operating nursing homes to about 2 percent of the yearly costs. I refer now to Louisiana. It would probably be a little higher than that in Florida, but nonetheless, there's no other way, nor more prudent way the State can attack that problem.

Senator **GRAHAM**. What could our congressional delegation do, General Peck, in order to move that partnership forward?

General **PECK**. I think there are two things. You can ensure, and thus far it has been proven, that there is enough money in the VA budget to handle all of the State applications which are fully authenticated and merit support. And the other is, that you might prove hinges in the budget, encourage the VA to continue to assist those State facilities after they are constructed.

Senator **GRAHAM**. Representative Reddick, following up on those comments by General Peck, one of the suggestions has been the

Veterans' Administration should give a greater focus on preventive care and other initiatives to reduce, moderate, or delay a serious illness. What do you think is realistic to plan in terms of preventive care services, and how might the State and Federal Government through the Veterans' Administration work together?

Mr. **Reddick**. Three points, Senator. Thank you very much.

First of all, the VA must adopt a philosophy that is more proactive rather than reactionary. That's No. 1. No. 2, with reference to the aging population, we must get those nursing homes, but we must also provide preventive care at an earlier point in screening so that minor problems do not become major problems. And the third point is, that we must have greater cooperation and interaction between the State and the Federal Government in anticipating this aging population.

And the good that would be accomplished by this, Senator, does not just accrue to the veterans, it would accrue to the citizens of Florida, because to the extent that veterans relieve some of that pressure of the aging population on our nursing homes, we are going to experience the benefit for all Floridians. In other words, Senator, what I'm saying is good for veterans, is good for all of the citizens of this State. And those would be the three points that I would urge, sir.

Senator **Graham**. General Peck, do you have any further comments on the question of preventive care strategy?

General **Peck**. No. I fully associate myself with the remarks of Representative Reddick, and I fully agree.

Senator **Graham**. As we have all commented, there has been a shortfall in Federal funds available for Veterans' Administration medical services. There have been some proposals, such as those made by Congressman Lewis, to initiate a demonstration project which would allow the VA temporarily to contract out for health care services until facilities can be built to meet the demands of veterans specifically in the Palm Beach County area. What are your thoughts on the potential of purchase of services and other forms of contracting out to meet the medical needs of Florida's veterans.

General **Peck**. If I may, Senator, I would start by saying I think first the VA budget should be adequately funded in total. Second, something needs to be done to assure more equitable allocation of those resources to Florida. Then, beyond that, recognizing that even if we do get new medical centers in Palm Beach and east central Florida, as in the program, there are veterans now between 65 and 70 who won't be alive in 10 years to enjoy those facilities.

I would suggest if the Congress is willing to assert and guarantee the veteran population of Florida, that whatever is done by way of fee basis or contracting, does not jeopardize the future construction of facilities necessary for the veteran population, and I would certainly support efforts to take care of the veterans now who cannot be taken care of in any other way.

Senator **Graham**. Representative Reddick.

Mr. **Reddick**. Senator, I would concur with General Peck's statement. My additional comment would be to meet the need, certainly let's contract for purchase of services, fee for services rendered, but at the same time let's also put in a strong evaluation component so that both the veterans as well as the other bureaucrats will feel confident that we are getting the maximum bang for the buck, and that our veterans are being treated well and our dollars are being utilized in the most expeditious fashion. Let's address the problem, but short-term solutions are not long-term solutions. Eventually we've got to have more dollars in the long term, but let's meet the need now, but let's have a strong evaluation component included. [Applause.]

Senator GRAHAM. Representative Reddick, General Peck, I want to thank you very much for extremely thoughtful testimony today. It will be an important part of our record. I want to thank you as a Floridian for the contributions that you are making to the veterans of our State.

Mr. REDDICK. Thank you, Senator.

General PECK. Thank you, Senator. [Applause.]

Senator GRAHAM. Would the members of panel two please come forward?

This panel consists of veterans' organizations from Florida. I would like to introduce the representative of the Paralyzed Veterans of America, National Director of the Central Florida Chapter, Mr. Jerry Dugan. Second, on behalf of The American Legion, Mr. Frank Reese, who is the State Manager, will introduce the spokesman for the American Legion.

Commander Reese.

Commander REESE. Senator Graham, on behalf of 100,000 members of the Department of Florida of American Legion, we welcome the opportunity to present to you, and members of the committee, the view of the Florida American Legion on the necessity of increased funding for the Veterans' Administration medical group throughout the Sunshine State. These views expressed in the Florida American Legion testimony are the opinion of the Florida Department of the American Legion, and may or may not necessarily reflect the position of the national organization of the American Legion.

I'm asking my legislation director, Bob Jackson, to present to you The American Legion position. I will relinquish my time at this point to Mr. Bob Jackson.

Senator GRAHAM. Thank you very much, Commander.

Representing the Disabled American Veterans is Base Commander, Mr. William Fabregas, who will introduce the representative of the DAV who will testify today.

Mr. FABREGAS. Thank you, Senator.

I think at this time, I would like to introduce Al Linden to give the testimony of the Department of Florida Disabled American Veterans, on my behalf. And at this time I would appreciate the privilege of allowing us to come before you for this testimony, and allowing Al to give my statement.

Thank you.

Senator GRAHAM. Thank you very much, Commander.

Representing the Veterans of Foreign Wars, Mr. Ed Shuman, legislative director for the Florida Department.

Mr. Jerry Dugan.

TESTIMONY OF JERRY L. DUGAN, NATIONAL DIRECTOR OF THE CENTRAL FLORIDA CHAPTER, PARALYZED VETERANS OF AMERICA

Mr. DUGAN. Good morning, Mr. Chairman. On behalf of the members of the Paralyzed Veterans of America and all veterans residing in the State of Florida, I greatly appreciate this opportunity to present views and concerns regarding the State programs and services provided by the Department of Veterans Affairs in the State of Florida.

My name, as you indicated, is Jerry Dugan, the national director of the Central Florida Chapter of the Paralyzed Veterans. The preponderance of the group's members reside in the Orlando area, in the central part of the State. PVA also has two other chapters located in Florida; the Florida Chapter in the Miami/Fort Lauderdale area, and the Florida Gulf Coast Chapter in the Tampa area. PVA also has a staff of service offices sited throughout the State to assist both PVA members and all veterans.

Mr. Chairman, all of PVA members have experienced catastrophic spinal cord injury or disease, and because of the nature of these disabilities, PVA members are very relied upon the VA's health care system, and are, thereby, very conscious of the pressures and problems currently besetting the system.

As the committee is aware, the DVA operates two specialized spinal cord injury centers in the State. There's one in Miami, and the other, of course, is in Tampa. While PVA members rely a great deal on those two SCI centers for medical care, we also have utilized other DVA facilities located throughout the State. Additionally, PVA service personnel deal with all the medical facilities in almost daily contact with the problems veterans are encountering.

The problems in the State of Florida appear to be the result of two very distinct factors. The first is the national situation with funding for veterans' health care. PVA has witnessed continual underfunding of the Veterans' Administration for a number of years. It is, for this reason, that PVA in conjunction with the Disabled American Veterans, the Veterans of Foreign Wars, and AMVETS has developed an independent budget for the VA which was submitted to this committee by our national president and our national office. I am confident that Congress, as they have in past years, will view this document as an honest assessment of the true needs of this Nation's veterans, and will work to improve the funding level recently contained in the administrative budget proposal.

The second factor is a unique Florida problem. The astronomical growth in our veteran population, while we all are proud of the many attractions of our State, these very conditions are contributing to the crisis that we are facing. For years veterans have been moving to the State in record numbers, either permanently or by seasonal basis. As the veteran population has grown, the system of medical care and services for veterans has not been able to keep pace. Now when these dual factors, increased demand and reduced resources, are present there can only be a possible outcome of deteriorating services and decline of availability of care.

PVA service offices report problems occurring at facilities throughout the State. Outpatient treatment at Miami, Key West, Oakland Park, Riviera Beach, and Orlando have been severely restricted. In all these facilities treatment for nonservice connected problems is only available to preclude the need for hospitalization. For these veterans who are either in category "B" or "C", and are not in need of emergency care, the outpatient care is totally unavailable.

In the case of the outpatient clinic here in Orlando, problems abound. First, the physical facilities are wholly inadequate for the number of veterans that have applied here. The facility is approximately 30,000 square feet and is currently seeing between 89,000 and 90,000 outpatient veterans. The extended waiting time has become the norm—the examination for a compensation and pension plans are continually delayed due to the shortage of those staff of the facilities. Over-the-counter medications and supplies have been discontinued for both service connected and non-service-connected veterans. This is particularly catastrophic for PVA members that require supplies on a daily basis, in order to maintain their well-being.

At the Bay Pine Clinic there are extensive waiting times for hypertension and renal clinics. It has been reported to PVA that the facility has a $9 million shortfall for utilities, laboratory chemicals, and prosthetics. The pharmacy is facing a shortfall of approximately $2 million. Presently the facility is still providing over-the-counter medications and supplies, but without additional resources their ability to operate during the fourth quarter is in doubt.

The Tampa hospital is currently operating in all its clinics, but it has been forced to close 36 surgical beds due to staff shortages. The inability of DVA facilities to be competitive in the recruitment of medical care personnel, particularly nurses, has reached crisis proportions. In spite of this, Tampa has not decreased its capacity, even though the facility is short 10 nurses. This can only result in potential problems in quality of care. The hospital is currently operating in a deficit in the areas of pharmacy and prosthetics.

Mr. Chairman, the situation at Tampa SCIU is a critical juncture. PVA has long advocated for additional SCI unit to be constructed at Gainesville, and for Tampa unit to be expanded to accommodate the ever-increasing demand placed upon it. PVA recently conducted a site visit at the Tampa facility, and found the unit to be in need of immediate assistance. Beyond the staff shortages, the physical facility was found to be inadequate for patient demand, and yet, we see other SCI facilities referring patients to this unit.

On February 28 of this year, PVA National President Jack Michaels——

Senator GRAHAM. Mr. Dugan, you have 1 minute, please, to conclude.

Mr. DUGAN. OK.

Our president went before you and recommended interim solutions. The solutions, and I'll just read here some of his verbiage. I have 1 or 2 more pages here, but I'll cut it short.

A recent visit to the center resulted in problems that occurred because of the crucial lack of clinical space. An additional building is required. If a permanent unit is approved in the fiscal year 1991 budget, the earliest occupancy will be fiscal year 1995 or 1996. And this is just too long. We simply cannot wait that long. The solution we recommend is a modular building of approximately 10,000 square feet to house 30 to 40 people for the effective operation of the center. We estimate the construction cost of this interim solution to be under $500,000. This seems to us to be an innovative way to solve this problem immediately.

Senator, I have some other testimony, but maybe what I'll do, it's all in written form, and I'll present it to you. And I really want to thank you on behalf of the veterans of Florida for conducting this hearing.

And I again point out there are two major forces at work effecting the quality and quantity of health care available to veterans here; one, the growing veterans' populations, which we have no control over; the second, inadequate resources, you hopefully can address.

I thank you, and at this time I'll attempt to answer any questions that you might have.

[The prepared statement of Mr. Dugan appears on p. 71.]

Senator GRAHAM. Mr. Dugan, thank you for very excellent testimony, and your full statement will be part of the permanent record. Questions will be held until after all the members of the panel have had an opportunity to speak.

Mr. DUGAN. Thank you.

Senator GRAHAM. Mr. Jackson.

TESTIMONY OF ROBERT J. JACKSON, LEGISLATIVE CHAIRMAN, THE AMERICAN LEGION, DEPARTMENT OF FLORIDA

Mr. JACKSON. Good morning, Senator Graham. We are very pleased to make this presentation today, even though we know that you are very well aware of the problems. However, your colleagues in the Senate and the House must be convinced of the continuing problems we face here due to the ever-increasing veteran population in the Sunshine State.

In the interest of brevity, Mr. Chairman, let me just summarize and emphasize the salient points presented on our written testimony.

First is the need to address the response time of the Federal Government for the budgeting process to properly fund VA medical facilities as it relates to the shift of population. The fiscal year 1990 budget is being constructed on experiences of veterans who have visited VA medical facilities for discretionary, nondiscretionary, and outpatient care in fiscal year 1988. That immediately puts the VA budget 2 years behind the real time delivery of the necessary funds-for-health gap. With an average of 4,000 veterans permanently moving to Florida each month, the 2 years of lapsed time means 96,000 additional veterans would have to be served, and is included in the fiscal year 1990 budget. At this pace, we will never be able to properly and adequately care for the veterans who are in need.

One area of immediate assistance in meeting the real life budgeting shortfall would be to allow the new Secretary of the VA to shift funds during the fiscal year to those medical districts that are receiving increases in veteran population. Two years ago the Administrator of the VA was given this authority on an annual basis, based on need.

Successive years of budgetary limitations have applied increasing pressure on the VA's ability to meet veterans' health care needs. The result has been shutting down of hospital beds, elimination of certain outpatient care, forced delays in most types of care, delays in opening new hospital and buying modern medical equipment, as well as the lack of proper maintenance for aging plant facilities. Accordingly, we ask this committee to use all the influence possible, through OMB, for a fiscal year 1988 supplemental appropriation of $314 million, and an appropriation for 1,539 full-time employees so that the VA may restore current services to the 1988 level.

The area of capital expenditures by the VA is one of vital concern to the veterans of Florida. As we sit here today there are no long-term psychiatric beds available for our veterans. For the issues of posttraumatic stress and other mental disorders, the outlook for veterans is bleak. Although this need was recognized by the VA Central Office 14 years ago in 1975, we remain the only medical district that does not have long-term psychiatric facilities.

Also, the VA must go forward with the plans to adequately fund the two additional hospitals that have been planned through the 30-year study, and the bedside study that has been developed by the 12th Medical District. It is also necessary for the spinal cord injury facilities to be included in the Tampa clinic.

We would like to bring to this committee's attention an issue we feel is a travesty of justice, and in that I'm referring to the mean's test and the copayment billing/collection system. When insurance companies reimburse the Government for care rendered in VA facilities, these moneys are sent to the Treasury as general revenues, instead of being credited to the VA. We feel this has a negative effect on the delivery of health care to the veterans. Recent figures released by the VA show the total recovery in 1987 was $23.7 million, 1988, $105 million, and in the first quarter of 1989 it was $39 million. We feel this money should be directly reimbursed to the VA since it is the Agency that funded the original care, and the Agency instrumental in collecting the funds.

In Florida with the increased population of veterans, accessibility to the facilities of the VA has reached the crisis point. Of the 27 Medical Districts, Medical District 12 has the lowest ratio of VA employees and facility access per 1,000 veterans. Based on 1987 figures, the 12th Medical District veterans have less accessibility to VA medical facilities than any other group of veterans in any other district.

Through your active and aggressive participation on the distinguished Senate Committee on Veterans' Affairs, we sincerely hope that the veterans of the State of Florida will begin to see a significant shift in VA funding for the 12th Medical District so that we may be able to care for every aging veteran who has served his country. Every day of procrastination on the part of Congress, by improperly budgeting the VA, is costing veterans their lives. The lack of adequate facilities can only be detrimental to the veterans' welfare. Although I am sure it is not the case, there seems to be an apparent lack of aggressive concern by many Members of Congress for the fact that veterans are aging, as though if we procrastinate long enough, the problem will die away. This is an attitude that could do great harm to the morale of this country.

Thank you for this opportunity, and I'll be happy to answer any questions. [Applause.]

[The prepared statement of Mr. Jackson appears on p. 77.]

Senator GRAHAM. Thank you.

Mr. Linden.

TESTIMONY OF AL LINDEN, LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, DEPARTMENT OF FLORIDA

Mr. LINDEN. Thank you very much, Senator. It's a pleasure for me to present the testimony of our commander, and on behalf of the more than 87,000 members of the Disabled American Veterans, and their auxiliary, I would like to take this opportunity to give you our general views, and to thank you for the opportunity to present these views.

As our national commander recently pointed out to a Joint Session of the House and Senate Veterans 'Affairs Committees, this country faces an acknowledged crisis in the area of Federal health care. In Florida this issue has been before us for years. This fact was recently brought to light by a killing in the VA parking lot, and it happened because this veteran had no place to go, nor no resource to turn to. As we all know, and we've heard the statistics, Florida has the oldest veteran population. It has the most seriously disabled population in the United States. And it is the most underfunded of any VA medical district in the country. It also has the fewest beds per veteran in the United States. Other States, for example, like Massachusetts has half the veteran population but has more beds than we have in Florida.

Hardly a day goes by when a veteran doesn't stop by our office, which is located just 15 miles south of Gainesville at the medical center, and state that he is unable to obtain adequate health care. However, let me state right here and now that it is not the fault of the Gainesville Medical Center. They, and the other facilities in Florida, do an excellent job with the resources that they have available to them. The problem is they do not have enough resources to meet the demand for services, let alone the demand that's going to be placed on them in the future by the movement of veterans to Florida.

Let me just give you some typical examples, and I would also like to present to the record, some letters from members of our organization who have written and wanted to make sure that their information and their particular facts got brought to light. These individuals have indicated to me that there is a monthly limit that's being placed on the dollar value of medicine for 100 percent service-connected veteran, that he can receive if he has a fee-basis card. We're rationing medicine in the State of Florida. Very bad. There's a monthly limit that's being placed by the VA on the amount of surgery that an individual can have. And it's documented right here. Ridiculous.

The VA's refusal to provide drugs that were prescribed by their own physicians is a problem. [Applause.]

I don't need to tell you, because I'm sure you and your staff hear it every day, about the delays in scheduling doctors appointments; 8 months to get an eye appointment, if you're lucky. [Applause.]

Three months to get a cardiovascular examination. Ridiculous. If the man needs it, he's going to die if he doesn't get it.

AUDIENCE PARTICIPANT. We'll die first.

Mr. LINDEN. We're talking about lives. These are but a few of the concerns that these veterans have expressed through our headquarters here in Florida. We could document hundreds more, but I think the people, and the witnesses, and the people that are attending this today bear witness to the fact that we have a very severe problem with our veterans in Florida.

I could go on and on. I could state the same statistics that the chairman stated in terms of the $45 million by the VA's own estimate recently, made to the House of Representatives as to what it would take just to meet the needs in Florida to bring them up to a standard for the current workload that would compare that to the civilian hospitals here in Florida, or the $160 million that's estimated by our own State Department of Veterans Affairs.

This is not acceptable to Florida's veterans, and the DAV strongly believes that immediate action must be taken by the Florida delegation to correct this situation. What can we do to improve? And I'll be very brief.

First and foremost, Senator Graham, you can introduce and work for the passage of legislation that would return third-party payments and other funds received by the VA back to the facility that provided that service. It currently goes to the Treasury general fund and is not available to the facility that provided the service. Two, expedite the building of the Palm Beach VA Medical Center. Three, introduce and work for the passage of legislation where dollars will flow to where the work is being accomplished. Currently, Florida facilities are sending prescriptions to the northern regions of this country to those patients who winter here in Florida. Fourth, you can assure that Federal funds are made available for the State domiciliary and for the nursing home construction and operation. Finally, and most importantly, work to increase the VA health care budget so that all VA facilities, including Florida's will have adequate funds to accomplish their mission.

In summary, the facts are that the 1.5 million veterans do not have adequate health care resources available to them in Florida. Therefore, their access to health care facilities is being severely limited. In fact, hundreds and thousands of veterans right here in the State of Florida are being denied needed health care treatment.

Senator, we desperately need your, and the entire Florida delegation's, help to correct the severe crisis that we face. Let's all remember to adequately care for those who have served this great Nation of ours, remember that America is No. 1 thanks to its veterans.

We thank you for the opportunity to appear here today and to present our testimony. And as the chairman of our service commission stated in a letter to Congressman Hutto not too long ago: "Congressman, what should I do, die so I won't become a burden to our country?"

Thank you. [Applause.]

Senator GRAHAM. Thank you, Mr. Linden.

Ed Shuman of the VFW.

TESTIMONY OF EDWIN H. SHUMAN, LEGISLATIVE OFFICER, VETERANS OF FOREIGN WARS OF THE UNITED STATES, DEPARTMENT OF FLORIDA

Mr. SHUMAN. Senator Graham, I'm honored to be here today and represent more than 100,000 members of the Veterans of Foreign Wars and its Ladies Auxiliary within the great Department of Florida.

However, I'm at a little disadvantage being the fourth to speak from a veteran's standpoint here. The other three organizations, probably, I could say have stolen my speech. [Laughter.]

It does prove one thing, that the veterans' organizations of this State are unanimous in their views on what is wrong and what could be done with medical care for the veterans in the State of Florida. It doesn't make a difference whether the DAV says it, the Paralyzed Veterans, The American Legion, my organization, or who it is, we all agree on one thing, we're not getting a fair shake in the State of Florida. [Applause.]

We are veterans, certainly, but we're also citizens and taxpayers of this great country of ours. And we're willing to take our share to get this country back on a good financial budget. But, when the Veterans' Administration budget for the last 8 years, if you reduce the inflation factor, did not gain any new dollars whatsoever, but yet the workload went up. Other Federal budgets have gone up. The budget for Medicaid since 1985 is up 55 percent; Medicare, 32 percent; the VA, 17 percent with inflation. Our workloads have gone up for the Veterans' Administration, at the same time that the budget stays the same thing. The 1990 budget would eliminate 9,000 health care workers from the Veterans' Administration, would reduce construction, and deny care. The VFW was absolutely opposed to such a thing, and we will fight any attempt to reduce 9,000 health care workers from the VA next year. [Applause.]

We also think it's high time that Congress tells OMB what the budget is, and not OMB tell Congress what the VA budget is. [Applause.]

We have heard that ever since little Davey ran the budget, and we don't need it any more.

Another thing, the VA is doing research for national health problems and is having to take it out of their own restricted budget. I am referring to the treatment for AIDS, alcohol, drugs, geriatric medicine, and Alzheimer's diseases. In 1983, the Veterans' Administration treated 211 cases of AIDS. This year 2,200. The VA is treating and doing research for things that are a national health problem and not strictly a veterans' health problem, and the VA should be budgeted for that, not take it out of their own budget. [Applause.]

I'm not going to reiterate the number of figures as to how old the veterans are in Florida. We have a growing—but it is a growing and aging population.

We also have here in Florida what's been referred to as a transient—we commonly call them snowbirds down here. I think the transient veteran, when he comes down here and is eligible for veterans' care, he should be given it. But there was a motto here in Florida several years ago, that said, "Keep Florida green, bring money." I think the Veterans' Administration in Florida should have the same motto. When a fellow comes down here from Montana, let him bring his money with him from the budget in that hospital, not from mine in Florida. [Applause.]

When Abraham Lincoln said to care for him who shall have borne the battle, his widow and his orphans, I think he meant all of us, whether we're in Wyoming, Massachusetts, or Florida, and within the States. To care for those who have borne the battle. Mr. Linden stated that Massachusetts has half the veterans and has more hospital beds than we do. Florida ranks 42d in the number of hospital beds.

I'd like to give you an instance of a veteran in Florida who went to the VA medical center at Bay Pines for an eye operation and it couldn't be given to him. He flew to Massachusetts, had the operation performed at the Boston Veterans' Hospital and came back to Florida. Now he could do that because he was a retiree from the airlines. Good thing he didn't retire from Eastern, he never would have gotten his eye operation. [Laughter.]

There's something wrong with the system. I'm not blaming the Veterans' Administration. Malcolm Randall, here, is an old buddy of mine. I've worked with the Veterans' Administration. I've been a patient in the VA hospital, and I've been a volunteer in the VA hospital. And I'll say this today, there's nobody that does a better job of health care than the Veterans' Administration, considering the resources available. [Applause.]

But there's a few things that have to be done. We need more outpatient care facilities. It's easier for some veterans to get in the hospital as an inpatient than as an outpatient. So it makes more sense to me to provide outpatient care than it is inpatient care. There's a television commercial that advertises something, that says pay me now or pay me later. That's what this is, pay me now or pay me later. But let's pay now. Keep the veteran out of the hospital, provide him with the outpatient care that he needs. The only thing that's going to happen is, our aging veteran population in Florida is not being adequately cared for, and the only thing that can happen to it is, it is going to get worse, not better.

Senator Graham, the VFW has some recommendations for you, too, but, here we go again, all these veterans said it ahead of me. We believe in this third-party payment. It should go back to the person that performs the service. We want the Palm Beach Medical Center built, and any others that are already in a planning stage for the State of Florida. Put the money where the service is done. We want you to work with the Florida congressional delegation to get more money into Florida on the 65/35 domiciliaries and nursing homes.

Senator Graham, when you were Governor of this State, a law was passed by the legislature directing a demographic needs assessment study in the State of Florida to find out how many nursing home beds were needed in this State. I was on the task force that helped do that, and at that time we needed 3,000 nursing home beds to just minimize what was needed for the veterans in this

State, and we don't have the first one yet. So it's high time we get some of them.

We want to see that the VA facilities in this State have the funds to accomplish their mission. They certainly don't have it now. I commend them for what they are doing. I think President Bush summed it up very well the other day when he said, we must care for those who have served their country. And that's all we want.

Thank you very much, Senator. [Applause.]

[The prepared statement of Mr. Shuman appears on p. 85.]

Senator **GRAHAM**. Thank you very much, Mr. Shuman, and this has been an excellent panel. I appreciate the obvious thought and preparation which went into each one of these statements.

One issue that has been raised in some of the testimony in Washington is that there is a suppressed demand for VA medical benefits. That is, that veterans who have heard about how difficult it is to get access, or have been concerned about other aspects of care, and who would otherwise be eligible for VA medical services, have decided not to even try. Have you had any evidence of that within your membership, Mr. Shuman?

Mr. **SHUMAN**. I think it might be true of those that can afford to go elsewhere. But that's not the question. Certainly, I know we have a lot of veterans here in Florida that probably because of low income can't get it. I don't think that strictly it's a fault of the Veterans' Administration. I've heard some veterans tell me, I'm not going out there and sit for 2½ hours to get waited on, to get served. My answer is, what else are you going to do, and the price is right anyway.

I think possibly there are some that because of the idea that they're going to have to wait in a line.

Mr. **LINDEN**. I know I've had several veterans come by our office and they've not only indicated what Ed said, but they've also indicated that it doesn't do them any good to go. In other words, the Doc is too busy to see them, a nurse will see them, give them a pill and send them home. So they go and tell their buddies, and basically, nothing happens. And so I think there is a suppressed demand out there for it. I've heard leaders of not only our organization, but other veterans' organizations right here in Florida say, it doesn't do any good to go to the VA, they're not going to treat you anyhow. And this is particularly true amongst the B and C category veterans. The VA itself has come out in various facilities here in Florida, and said we're not going to bother treating those people—we don't have the resources to treat those people. And they've made public statements to that effect.

So, I think, yes, there is a suppressed demand out there for these services. And I think that it shows up in the severity of when the veteran does go. I went to a prison. I was called to go to the Marion County Prison to see one of our veterans. And that guy, it was so bad—he was a double-arm amputee, and they were giving him the wrong kind of soap, and he had a skin condition, and he was so bad that he couldn't even walk. But thanks to the VA again, once that problem was brought to light, you know, they immediately acted upon it. So, yes, I think there is a suppressed demand.

Senator **GRAHAM**. Yes, Jerry.

Mr. **Dugan**. Yes, also, I feel that our members, I can reiterate what my two colleagues have said, we find basically our members with a major disability, the problem is timeliness. They've got to have attention now. So they are seeking medical care elsewhere. This is a big problem.

Senator **Graham**. Previously, I mentioned the fact that there has been a proposal for a demonstration project in Palm Beach County of a purchase of service until such time as the VA facility is available there. What is the position of our organizations relative to the purchase of health care services by the Veterans' Administration for the benefit of veterans?

Mr. **Shuman**. I'm against the Veterans' Administration bailing out bankrupt hospitals, if that's what you're referring to. And I'm also against anything that down the line would lead to the destruction of the Veterans' Administration health system. Now, if it would be possible, I don't see why it couldn't be done without designating a particular hospital where the individual has to go. Why not let the veteran just go to his own private doctor? Most of us have one, anyway, rather than running someplace to another hospital. If he needs treatment, let him get it from his own private doctor, and then the VA pay for it. [Applause.]

I'd like to be awfully sure, though, that the Veterans' Administration, itself, could not provide the service. I don't want it turned loose where everybody can go wherever they want to, because then we're going to lose the finest hospital system in the free world.

Mr. **Linden**. I think it comes down to a question, again, of resources. In talking with Malcolm, and he's probably got to deny it for public reasons, but in talking with other administrators of hospitals, they've got case after case of where they've delivered this same treatment much cheaper. So I'm not sure that that solves the problem. I think first you've got to get the resource down here, give it to the VA, and let them decide how best they can do their job. That's what the system is about. It is the greatest and largest system in the world of health care systems. And they have done in the past, and given the resources that they need, they're doing an excellent job. But, again, it's resources. And I think if you ask them, they'll basically tell you that most of the time they can do it cheaper and more economical than can the others.

Another area that was addressed by our national commander, was the sharing arrangement. Now, in Florida that doesn't help a lot, sharing with military facilities, because they've got problems too. If you're a retired military, you can't get into the base hospital to get treated there either, because they don't have the adequate resources. But in other parts of the country, that seems to be working. So I think a solution here is the reallocation of the dollars and the resources that are available to the VA, plus more funding for the VA. Let them make that decision, not the Congress, or not the individual veteran. Because, right now they're yanking fee-basis cards. I've got guys that come by every day where they used to be dealing them out, they're now yanking them back and saying, if you want treatment, you've got to go to the VA hospital to get it. He gets there, he waits all day, they don't have adequate resources to get the job done. So, it's a resource—it's a dollar problem, and until you solve that problem, any other solution is of a secondary importance.

Senator GRAHAM. Jerry, did you have a comment?

Mr. DUGAN. No, I would just again reiterate from my colleagues there, our resources—we've got to spend—the House Appropriations Committee did a report on the VA and cites case after case where the VA can do the medical needs a lot cheaper than the private sector.

Senator GRAHAM. Yes, Mr. Jackson.

Mr. JACKSON. Senator Graham, I just believe it's precedent setting to try to do something like that, and as it has been said, it's a matter of resources. It would seem that if the money is available for the so-called chit system to be used in a certain area, that that money would not be spent wisely. We'd be applying a Band-Aid to a program in a small portion of the country whereby we might be able to use those resources to put a tourniquet on the whole system.

Senator GRAHAM. Yes.

Mr. SHUMAN. I don't see why we should use money to send the veteran to a private hospital, when there are beds vacant in the hospitals in Florida, and all we need is the resources to open those beds back up and staff them, and go again. Why fill this bed when there's 50 up there that's closed because of lack of resources. And where's the resources coming from to do this?

Senator GRAHAM. One final question I'd like to ask for comments of the panel. Have you seen any evidence that the VA medical system's problem has resulted in a reduction of the overall standard of health among Florida's veterans?

AUDIENCE PARTICIPANT. I'll be the guinea pig. That's a very tough question, but the answer, I think, has to be, yes. I've talked to doctors at the VA hospitals that have said, you know, hey, I've got to give this guy an aspirin and send him on his way. I ought to be seeing him five and six times a year, because that condition is going to get worse. I know it's going to get worse, but I can't treat. I mean, I don't have the resources available to me to treat him on a continuing basis. I ought to be seeing him every 3 months to see if its worsening. You take a guy that's got glaucoma. You've got to watch that very carefully, because it's—and I'm not a medical doctor, but since I'm going through it, I understand the problem, that if you're not seen regularly on that it can deteriorate and then you're in really bad trouble.

Mr. SHUMAN. The answer is, I think that the quality, and that the veteran himself, there is a deterioration simply because he can't get the preventative care that he needs up front to prevent something serious from going on down the pike later on.

Senator GRAHAM. Yes, Mr. Jackson.

Mr. JACKSON. I might just add, Senator, that The American Legion did a survey 2 years ago with the advent of the means test, which showed that 95 percent of the people using the VA hospitals had no other place to go. They could not afford any other help.

So, yes, I would say that we are seeing a decrease in the health of the veterans only because these people have no place else to go.

Senator GRAHAM. Any other comments?

Mr. **Shuman**. I'll agree with that. The majority, a lot of them, low income, fixed income. If they don't go to the VA they have no other place to go, and so with that effect their health would be going backward. Of course, you have to remember which one you're talking about. Now, are you talking your service-connected veteran or your non-service-connected veteran, which does make a difference.

Senator **Graham**. Gentlemen, I appreciate very much your excellent testimony. This will be extremely helpful to the committee.

Mr. **Jackson**. Thank you, Senator.

Mr. **Shuman**. Thanks, Senator.

Mr. **Linden**. Thank you. [Applause.]

Senator **Graham**. Panel No. three, please come forward.

As I indicated earlier, at the conclusion of the four panels, we will have an opportunity up until 1 o'clock for individual members of the audience who wish to make a statement to do so.

Panel No. three is Deborah Shannon, director of social services for South Seminole Community Hospital in Longwood. Ms. Shannon has a masters degree in social work. She will be representing the hospital social workers from the private sector, testifying on the problems of private hospitals encountering serving veteran patients. Also speaking is Mr. Clyde Cleveland, the Volusia County Veterans Service Officer. Mr. Cleveland will discuss a variety of problems of veterans seeking VA health care and assistance.

Ms. Shannon.

TESTIMONY OF DEBORAH L. SHANNON, DIRECTOR OF SOCIAL SERVICES, SOUTH SEMINOLE COMMUNITY HOSPITAL, LONGWOOD, FL

Ms. **Shannon**. Senator Graham, and members of this distinguished committee, I am very honored that I was asked to make this presentation today as a representative of hospital social workers in the private sector. I am proud to represent South Seminole Community Hospital, a small acute care facility located at Longwood, which is just north of Orlando.

Many of our staff members and physicians are also concerned about the issue of health care for veterans. My presentation will not contain numerous statistics, but will basically deal with human issues that a private sector hospital encounters as it relates to the veteran. These issues relate mostly to the first and fourth areas of investigation, dealing with availability and future needs. Also, most of the discussion deals with the veteran that has no third-party payment source and seeks admission to the VA system.

We have had limited success and are greatly concerned about the future need of the Florida veteran. Sometimes veterans experience emergency situations that result in acute care hospitalization at the nearest private sector facility. The veteran is usually asked at that time if he desires transfer to the nearest VA facility. The veteran, who is normally treated at the VA hospitals, and/or is 100 percent service connected usually requests transfer. The veteran who has no third-party payments, or might have some insurance with inadequate coverage also will request transfer. Often such a veteran has never accessed the VA system or might have a non-service-connected disability. Seldom does a veteran with insurance coverage request transfer.

Once this request for transfer has been expressed, a hospital representative will contact Fee Bases in St. Petersburg to initiate a check regarding the veteran's eligibility in the VA system. A social worker will automatically call the proper VA facility in the veteran's catchment area to request transfer if it is known that the veteran is non-service-connected disabled. It has been a fairly standard belief among private sector hospitals, and hospital social work directors in my area, that this as far as this request will go.

Availability to the VA system for the veteran who is non-service connected, who has never accessed the VA system, or his primary admissions diagnosis is not related to the service-connected disability, is extremely difficult to accomplish in the State of Florida.

I, again, stress the veterans who are often requesting transfer from the private sector acute care facility into the VA system are those veterans who have no third-party payment source, have probably been employed and have found themselves in need of an emergency admission to the nearest local hospital. It was through the desperation of one such veteran, and his ordeal to achieve access to the VA hospital, that I am sitting before you today. Perhaps the best way to succinctly explain the frustrations such veterans often experience is to retell a condensed version of the story.

A veteran from north Florida was in Orlando working on a construction job when he became ill. He had a stroke, and presented himself to South Seminole Community Hospital's emergency room. This veteran, his wife, and his sister were all concerned that he be transferred as quickly as possible, as he had no third-party payment source. The veteran had also never been ill, and had never had reason to use the VA system. The veteran's sister was from a Northern State and had previously worked for the VA in that State before her retirement. I reassured her that the request for transfer had been made. I further explained it was common experience that such a transfer would probably never transpire before that patient, that veteran, was ready for discharge from our hospital. The sister was appalled and uttered the standard statement heard in almost all similar situations: Is it not the function of the VA to provide free medical care to all veterans in need of such care, who have served their country?

It is hard to explain the Florida VA system to veterans and family members that are not actively involved in veterans' organizations, or who are accustomed to using VA's facilities outside the State of Florida. It is hard for them to understand that this system is overburdened and probably has not received its fair share of Federal allocations based on the number of veterans in our State. Furthermore, it is extremely difficult to transfer a stroke patient, or a spinal cord injury patient from an acute care private sector hospital into a VA rehabilitation program. It is hard for veterans and families in crisis situations to understand this rationale.

However, this sister was a very determined person, and she started to call the VA in Washington, DC, who apparently had put her in touch with Senator Graham's office in Tallahassee. She also asked me to make calls on the family's behalf, for they were in great fear of losing their life's savings. I called Senator Graham's staff person, and we discussed the frustration the private sector hospitals encountered when attempting to transfer the veterans who have no third-party payment source, or inadequate insurance coverage. I was asked why other hospital social work directors, or social workers do not call or write more often regarding these problems.

It was after this that I started to call, and obviously the staff person either remembered my name or I became a thorn in his side, I'm not sure which. But, nevertheless, I was very honored when I was asked to testify here today. I did call my other counterparts in the central Florida area hospitals, and although none of us keep real statistics on the number of veterans who did not get transferred, we basically are all in agreement that it is very difficult to transfer a veteran who is non-service-connected, who has never used the VA system, or who's primary diagnosis does not relate to the reason the person is 100 percent disabled. Also, many times even the service-connected veterans do not get transferred if bed space is tight.

Senator, and distinguished committee members, I have presented to you a common example of the problems that a small acute care hospital experiences in relation to a veteran in need of the VA hospital transfer. In the past 6 months my statistics show that three veterans who had never used the VA system were transferred after much time-consuming effort on my part, the part of the veteran's family, and a dedication of a few physicians who cared. At least four veterans, and maybe more, did not receive such a transfer. South Seminole statistics might seem insignificant, however, multiply these statistics by the number of acute care private sector hospitals in the State of Florida. That number should give a fair representation of the number of veterans who do not receive access to these type of facilities.

Why do people in my position not speak out? I cannot answer for others in my profession, however, I do know how much time was spent to make these three transfers happen. Time that involved the extreme effort of myself, the families, and the physicians. Desired results were achieved only after enlisting the assistance of congressional action.

What happens to the veteran in the State of Florida who does not have such people advocating on his or her behalf? It is hard to believe that a system that is supposedly designed to be of assistance to the veteran in need, often leaves many with a bitter, frustrating experience. The Florida veteran deserves much better. The Florida veteran deserves a VA system that is adequately funded to meet the real needs of the veteran population in our State.

I thank you for this opportunity to express my opinions, and I would be happy to answer any questions you might have. [Applause.]

[The prepared statement of Ms. Shannon appears on p. 93.]

Senator **Graham**. Thank you, Ms. Shannon.

Mr. Cleveland.

TESTIMONY OF CLYDE CLEVELAND, PRESIDENT, COUNTY VETERANS SERVICE OFFICERS' ASSOCIATION OF FLORIDA

Mr. CLEVELAND. Senator Graham, I would like to thank you for this opportunity to appear before you today, and on behalf of the County Veteran Service Officers Association for the State of Florida, of which I am president.

My distinguished colleagues have covered a lot of things that I was going to talk about, but I still have a few things left. One problem is the turnover of personnel due to the lack of competitive salaries in comparison with the private sector. As it stands now, the VA is simply a training ground and it loses good qualified people to higher pay and positions outside the Veterans' Administration at a consistently rapid rate.

Another problem is veterans with posttraumatic stress disorder, who are suicidal or homicidal and sent by court order, or through emergency care from private hospitals, are being subjected to professionals who tell them that they are just in hospitals trying to get 100 percent service-connected disability rating for the PTSD. The professional dealing with these veterans should not concern themselves with anything except the treatment. Many misdiagnoses are given PTSD veterans separating their problems into many other psychiatric disorders, which is wrong. The professionals at the VA medical facility who are concerned that these veterans should not be given ratings at 100 percent, are following this technique to show that the PTSD problem is only a percentage of the veteran's psychological problems, and are therefore reducing the rating for the PTSD. Actually, the diagnosis should be the aim of the professional rather than the effort to adjudicate the veteran's claim.

Another problem is cutting off a veteran who doesn't show up for an appointment. For some reason we have a problem with the VA never notifying the veteran that he has an appointment. The law says "sorry, you're cut off"—through no fault of his own. To get him reinstated it takes 2 or 3 months sometimes, sometimes it's easier than that.

Agent orange veterans have many problems, whether psychologically or medical problems with skin disorders. Doctors seem reluctant to write a diagnosis on their evaluation chart. I think specialized physicians should conduct evaluation examinations completely and fairly, even if it takes a longer timeframe. Often claims must be refiled because conditions were not considered during the physical that should have been routinely part of the examination. This problem results in a workload and expense both to the VA and the county service officers in processing paperwork. All too often the veteran relates that his exam was conducted in a manner that did not allow him to discuss any of the medical complaints, and that consultations were nearly nonexistent.

Along with what Deborah said, veterans that are admitted to civilian hospitals have difficulty getting the VA notified within the 72-hour time limit, because the social worker, the doctor, or the nurse do not understand the importance of the 72 hours. Once the VA is notified, then all at once the veteran either gets better and he is discharged to go home, or we end up with a problem trying to get him transferred. I do not feel a veteran should be punished for the neglect of the hospital staff. He should be given the benefit of the doubt. A possible solution would be to take steps by law, or to place monetary responsibility/liability on the treatment facility who fails to cooperate.

There should be a change made to reward veterans for being rehabilitated. Presently the system encourages veterans to remain sick, for fear that disability compensation will be taken away if they attempt to find employment or gradually work toward being self-sufficient. This problem could be remedied if when a disability is given it is made permanent, or the veteran may be given a lump sum. The idea that a veteran lives in constant threat of having his income removed causes great concern and interferes with the quality of care of patients, particularly in the psychiatric area.

Nursing home and adult congregate living facilities need to be discussed. The medical care service picture has changed over the years because of diagnostic regulations, called "DRG's". Since Medicare will not pay for long-term hospitalization under the diagnostic admission, people who do not heal quickly, elderly and those with multiple medical conditions, are sent to nursing homes. More care is required in nursing homes now than in the past due to this shift of responsibility. Adult congregate living facilities are, in turn, now becoming the nursing homes of a few years ago, and consequently, accepting people who require assistance with daily self-care activities, mobility, providing prepackaged doses of medication. Medicare does not cover ACLF since they are not in the same category as nursing homes.

Many veterans who are eligible for nursing home care choose to enter an ACLF instead, which includes missing room and board as an unreimbursed medical expense. The law should be changed to allow the veteran to consider these same expenses when care is provided at an ACLF. In those cases where the patient's condition allows some latitude, and the option is taken for an ACLF, the Veterans' Administration should not penalize the individual for the choice of a more comfortable atmosphere by disallowing expenses for the room and the board.

More emphasis should be placed in treating our veterans at other places than hospitals and nursing homes. To help the situation we need to use more hospital- or clinic-based home care, allowing the veterans to stay at home. In addition, there are programs at clinics and at hospitals, such as adult day health care programs, which help keep patients at home, and yet they can be cared for elsewhere during the daytime. This would be especially valuable for patients that would be so sick as to be borderline nursing home care patients, and yet have the supportive family at home. The adult day health care would provide a better quality of life and would offer some relief for the families of veterans. Their families would be happier, and the cost would diminish. You need to explore more and more with our aging veteran population.

Veterans particularly with emotional disorders are given 100 percent temporarily while hospitalized, and then overpaid because the proper paperwork is not acted on in a timely manner by the VA when the veteran is discharged from the hospital. Then the veteran is asked to repay the overpayment and this causes great hardship on the veteran.

I suggest since psychiatric episodes are allowed a period of convalescing, that posttraumatic stress and other emotional disorders also be allowed this period of convalescing.

I have a lot more here, Senator, that I could go into but I want to thank you for giving me the opportunity to speak. You have the written testimony. I'd be glad to answer any questions.

[The prepared statement of Mr. Cleveland appears on p. 100.]

Senator **Graham**. Thank you, Mr. Cleveland. I appreciate your testimony, and it will be printed in full in the record.

Mr. **Cleveland**. Thank you.

Senator **Graham**. Ms. Shannon, you talked about some experiences relative to the transfer of patients from private facilities to a Veterans' Administration hospital. Could you describe your sense of the effort that has been made on behalf of the VA in facilitating those transfers?

Ms. **Shannon**. The VA is always very courteous. We've never had any problems along those lines. It's just that acute care settings are under such pressure with Medicare and DRG's and the doctors—there seems to be a time lag there that we need to move them out right away, and the VA, for some reason, they never seem to have the bed space, especially as I said, for those non-service-connected veterans or the veteran that's never accessed the VA system. They have to check their record first to make sure they were honorably discharged. So there's a lot of leg work that needs to go on. And we find too much time elapses and the person is usually ready for a discharge from our facility before they're ever transferred.

Senator **Graham**. I asked a question to the previous panel on the issue of suppressed demand. From the veterans that you see come into your hospital, or other similar hospitals in this region, what is your assessment of the number of veterans who either because of their concern about lack of access, or fear of delay and other reasons, who would otherwise be eligible for services of the VA system, have elected not to attempt to secure such services?

Ms. **Shannon**. Well, the veteran that we—hopefully we find out that person is a veteran when they come in and we're going to request transfer, because they don't want a large hospital bill, and we don't want them to have one. My concern is that most of the veterans I see that aren't in the Medicare population that want to go onto the VA system, are people that are employed, and for some reason, whatever reason it might be—maybe their employer doesn't have a group insurance, they do not have any insurance coverage, so their main concern is not to acquire a large hospital bill, and they want to be transferred out. And it's just that those persons, for some reason, we just can never seem to get them into the VA system.

But my concern is somebody in society, some agency, some group, be it the VA, be it county welfare, be it the Medicaid system, whatever, somebody usually ends up paying that hospital tab, if this person does not get the medical attention they need, and hopefully be able to return to work.

Senator **Graham**. Mr. Cleveland, you talked about some changes in other health care policies, such as the DRG Program and Medicare, and what effect those changes had on post-hospital services such as nursing homes. Are there other examples of where changes in a nonveteran's area of health care policy have caused an impact on the Veterans' Administration system?

Mr. **Cleveland**. Well, I think the older veteran population of today, in our county in particular. We have 72 nursing homes in the county, and I have a counselor and all she does is go around and see veterans in nursing homes. And our problem is the requirements by the VA. We need a letter from a doctor saying an individual has to be in treatment in a nursing home, that he's not able to take care of himself, and there are certain departments, and, yes, I guess it does have a great impact on it.

Senator **Graham**. You raised some serious and specific issues on the quality of VA medical care. Do you believe that quality issue is directly related to the budget issues that have been raised previously today by the preceding panels?

Mr. **Cleveland**. Yes, sir, I believe it is. And I'll give you an example of what one of my distinguished colleagues talked about, that is the formulary that the VA system has where they come up with a list of drugs that are prescribed for certain veterans. And I have quite a few veterans that the drug is not made available to them because it's not on the formulary. When we tried to get the drug through our drugstore and submitted the bill to Bay Pines, Bay Pines refused to pay 100 percent service-connected veteran for the drug because it was not on the formulary. Yet, this individual could go over into Georgia or Alabama—I checked in three or four different other States—and get the drug that he needed, when the doctor said no substitution, because the veteran tried a generic drug, and the generic drug caused him problems. So when he went back to the drug that was prescribed for him and it was not on the formulary, he could not get reimbursed, and in one case 30 pills of this particular drug cost him $47 and some odd cents. And I don't think it's right that 100 percent veteran should have to pay for his medication.

Senator **Graham**. Why was there a different treatment of that veteran in Florida, than the other States that you surveyed?

Mr. **Cleveland**. Well, it's the formulary that they have come up with, and the generic drug is a lot cheaper, if someone can use it, than the drug that was prescribed for this veteran. And I think they believe that this is going to save money, and in all cases this does not work. If the veteran can take the generic drug, then I think it's fine. But we have cases, like two or three that I have in my county, that cannot take the generic drug, and the doctor says no substitutes.

Another problem we have is doctors refusing—they say they're medical doctors, they refuse to fill out the paperwork in this particular instance, I think the VA has a form that the doctor could write a statement on this, then we could send it in and Bay Pines would evaluate it. And this particular doctor said, "I'm the medical doctor. I'm not an administrator," and he refused to fill the form out. So we have problems in that area also. This was not a VA doctor. This was a civilian doctor.

Senator **Graham**. Mr. Cleveland, Ms. Shannon, thank you very much for excellent testimony. I appreciate it. [Applause.]

Panel four.

Our final panel is Mr. Donald D. Thompson, Southeastern Regional Director, Department of Veterans Affairs. Mr. Thompson began his career with the VA 25 years ago, and has since held progressively more responsible positions. In 1981 he was appointed to the position of regional director. Mr. Thompson received his MA degree from Stetson University in Dunnellon, FL, and currently resides in Hawthorne, FL. Mr. Malcom Randall is Director of Medical District 12 in the Gainesville Veterans' Administration Medical Center. Mr. Randall served in P-2 boats in the South Pacific during World War II, and he was formerly the Air Staff Commander of the Naval Air Reserve Unit in Jacksonville. Since that time he has been a leader in hospital administration and health care policy at the State, Federal, and international level. He has served as a member of national and State task forces and committees in the health care field.

Mr. Thompson.

TESTIMONY OF DONALD B. THOMPSON, DIRECTOR, SOUTHEAST REGION, VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. **Thompson**. Thank you, Senator. I am very pleased to be here today to represent the Agency. You have my formal statement, and if I may, I'll just give you a short summary of that statement this morning.

The Department of Veterans Affairs provides health services through five hospitals and nine satellite outpatient clinics in Florida. As you've heard, the veteran population is now estimated at 1.484 million, and we have facilities containing 2,916 hospital beds, 840 nursing beds, and 200 domiciliary beds to serve these people. The combined employment ceiling in the Florida facilities is 9,015 full-time equivalent employees, and the aggregated budget for 1989 is $479,555,000.

We've made significant improvements in the budget of Florida medical centers. In 1974 the combined budget totaled $110 million. By 1980 it had grown to $239 million, more than double the 1974 figure. By 1989 the budget had grown to $479.6 million, a redoubling. The percentage of growth in the Florida facility budgets has clearly been greater than the percentage of growth in the total medical care budget. During the same time, all nine of the satellite clinics have been established, a replacement hospital has been built at Bay Pines and every medical center in the State has had major additions and renovations, including nursing home care units totaling the 840 beds I mentioned.

This does not mean that funding is adequate to meet the needs of all entitled and eligible veterans residing in the State. I testified before the Senate Committee on Veterans' Affairs on September 9, 1988 to budgetary shortfalls in this region, approximating $80 million, roughly $20 million of which was identified for Florida facilities. These shortfalls are created by an erosion of our recurring bases at the medical centers due to insufficient funding of inflationary cost increases, to repeated absorptions of personnel costs, to consecutive applications by OMB of a 1 percent productivity based reduction, to absorption of costs of increased entitlements and administrative requirements which were unfunded when the legislation was passed. These shortages have caused our directors to divert equipment and maintenance funds to buy supplies and services, which poses a serious threat to our quality in the long run if the equipment and facilities are allowed to deteriorate.

In the fiscal year 1989 funding allocation, the largest we've ever had, we simply cannot offset these shortfalls, and it is insufficient to maintain current services. The improved funding of the Florida hospitals has come from the general medical budget, principally through activations and our resource allocation methodology. The Chief Medical Director, during the planning for the 1989 budget, set a policy of equity of excess across the system, and distributed funds on the basis of priority of workloads, specifically fixing the allocations to the percentages of discretionary and nondiscretionary workloads. The Southeast region's actual experience was set as the target level for the entire system. This meant that significant numbers of lower priority veterans whose care is not mandated by law, and is subject to the availability of space and resources, would be excluded from care.

This region was given $5 million additional as a result of the data validation process in the resource allocation methodology. And this, together with our RAM earnings, due to performance on the DRG-based system, has put us close to parity with other regions.

The impact of the shortfalls, I won't go into because you've heard them, and I concur in everything the other witnesses have said today, as to the impacts on the veteran care.

The quality of the care, however, is still high. But that service is being rationed. We have adequate bed levels within the primary service areas of existing facilities, but have large, densely populated areas that are underserved. Florida, as you've heard, has the third lowest beds per thousand veterans in the country. If all of the planned facilities that are in the 30-year needs plan for the State of Florida were to materialize, we would reach only a level approximating the average beds per thousand for the Veterans' Administration as a whole.

Outpatient care is of excellent quality, and with a total of 1.256 million visits, our market penetration per 1,000 veterans actually exceeds many other areas. However, the veteran population, as you've heard, in Florida has a higher than average percentage of service-connected veterans, so access by non-service-connected veterans is poorer than is found in most areas. In fact, in some specialty clinics category A veterans are experiencing long delays and reductions in services.

So, in summary, the recurring base for Florida health care facilities has been eroded, and care is being rationed restricting free access to that care. Available dollars have been reduced at a time when the demand continues to grow. We cannot continue to maintain current service levels with the dollars available, and the reductions in workload rather than in quality are our only acceptable means of maintaining the quality of care.

Thank you.

[The prepared statement of Mr. Thompson appears on p. 107.]

Senator **Graham**. Thank you, Mr. Thompson.

Malcom Randall.

TESTIMONY OF MALCOM RANDALL, DIRECTOR, MEDICAL DISTRICT 12, VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. **Randall**. Thank you, Senator. It's a pleasure to appear before this committee, particularly since it's being chaired by you, Senator Graham, who has done so much for the veterans in Florida. And it's also a distinct advantage to the veterans of our State that you are a member of the Senate Committee on Veterans' Affairs. And we are grateful for that.

Mr. Thompson has talked about some of the initiatives that we have made in this medical district, bringing more facilities to Florida. And I'd like to pay tribute to the veterans' organizations who have been a part of our medical district's initiated planning process in this medical district. The Department commanders have appointed representatives to our Veterans Review Group, which is a part of our planning process. And I see a few people here today who have been involved in our planning; we've had bed requirement studies, bed siting studies, and identification of outpatient needs. I see Dyke Shannon, Tracy Taylor, Dan Hall, Mike Hann, and Al Linden who has just joined us. If I've missed anybody, I apologize. But the veterans' organizations working with us in our planning process here contributed significantly to the identification of our needs, and I think to the validation of those needs.

Mr. Thompson has already talked about the fact that we have more outpatient clinics than the other States in the country, and that has meant a shifting of resources to this State, the dollars that come with the clinics since they've been opened.

This medical district has the lowest number of total psychiatric beds per 1,000 veterans of any district in the Nation, and it has essentially no long-term psychiatric beds. Because of this critical need, working with Mr. Thompson, a few psychiatry beds at Bay Pines and Miami were redesignated as extended psychiatric care, but over the long haul this is only a stop-gap measure and this problem will not be addressed until the planned 290-bed long-term psychiatric facility at Gainesville is constructed. There will be 200 long-term beds and 90 acute beds.

An additional high-priority need, and this has been mentioned previously, is a planned clinical addition and spinal cord injury addition at Tampa. This is critical. This project has continued to slip, and construction is now scheduled for 1992.

Although the operating budgets for the hospitals in this medical district have increased year after year, and in fact, significantly increased over the past several years, the amount available simply has not kept up with the costs and demands for care. There's been a slow, almost inexorable year after year erosion of the recurring dollar base, so that the cumulative effect has finally reached a critical state in fiscal year 1989. And this erosion was the result of our funding failing to meet our actual costs in terms of inflation, personnel costs, increased entitlements, which were legislated but not funded, and the OMB imposed 1 percent productivity cut year after year. This steady erosion, year after year, of our recurring base means that we are unable to maintain the level of service provided in fiscal year 1988, and at the same time maintain quality care.

Although the outpatient workload has continued to increase, it would have increased significantly more than it has if it were not restrained due to resources. In 1989 all VA medical centers in this medical district have had to reduce the number of discretionary veterans who receive care. This has meant curtailing services through applying of priorities for care, particularly for non-service-connected veterans who need long-term chronic care. These veterans are being dropped from the rolls, or are not picked up initially, even though community resources might not be available to them. Many veterans moving to Florida who have received continuous care in other States, are not being provided care, simply because we don't have the resources to continue their care. This selective disenfranchisement of certain patients, who are considered discretionary from our eligibility point of view, has caused concern among our physician staff. They feel that there is an ethical question if patients are turned away who need care and who may not be able to get that care from another source.

One other factor should be mentioned. The slow erosion of our recurring base has been laid on top of a low staffing pattern that has existed for years. The rapid advance of American medicine has brought new and increased diagnostic and treatment modalities which always require more and more people. Looking at our medical centers today we find that they are massively understaffed when they're compared to the staff of similar sized and type hospitals in the private sector. I looked at some data just this last week. All hospitals reporting to the American Hospital Association in the calendar year 1987, had an overall staffing ratio of 4.29 full-time equivalent employees per patient. Nationally, VA hospitals had an average staffing ratio of 3.20 FTEE per patient. That includes all VA hospitals that could be classed as teaching hospitals. Now, since teaching hospitals, because of their higher intensity of care, have a much higher staffing ratio, I took a look at that. The typical medical school teaching hospital in this country has a staffing ratio between 6 FTEE and 9 FTEE per patient. In contrast, the VA hospitals affiliated with medical schools in Florida have a staffing ratio of from 3.6 FTEE to 4.6 FTEE per patient.

I looked at a regression analysis which was prepared by a university recently, taking a look at the staffing patterns in university teaching hospitals across the country, and found some interesting data relating to staffing patterns. If this regression formula were applied to the principal VA teaching hospitals in Florida, the following additional personnel would be required to bring VA staffing up to a level comparable to similar private sector hospitals. At Gainesville, we would require 963 FTE additional; at Miami, 536 FTE additional; at Tampa, 912 FTE additional.

These are some of the issues that weigh upon us in addition to the shortfall of dollars that get in the way of our providing the amount of care that we would like to provide in Florida. Despite all the pressures, despite all the shortfalls, I am quick to add that the quality of care that is being provided to hospitals and clinics in this medical district is high. Admittedly, we are not taking care of all the patients who present, but let me reiterate: The quality of care that is being provided is high. But this is because of an unusually competent and dedicated group of people who staff our medical centers and our clinics. They carry a much heavier workload than their counterparts in the private sector, and unless the shortfalls that we have talked about here today can be addressed, I am not certain how long we can continue to keep this caliber of person in our facilities.

We've made remarkable progress in getting new construction for Florida. We've made remarkable progress in opening new outpatient clinics. However, the steady and inexorable erosion of our recurring base over a number of years, coupled with the unprecedented demand for care brought about by the movement of veterans to Florida, means that we can no longer continue to provide current services at a quality level with the dollars now available.

That concludes my statement, Senator.

[The prepared statement of Mr. Randall appears on p. 115.]

Senator **Graham**. Thank you, Mr. Randall.

Mr. Thompson, on page 2 of your testimony you state that the implementation of our planning initiatives in the last 4 years has been essentially limited to redirecting resources within the region moving them from lower to higher priority of need. At this time what does your planning process identify as the five highest priority items in this medical district?

Mr. **Thompson**. Ours is not exactly in the same order priority as the Agency submitted them. Our region felt that the highest priority for projects in this region would be: No. 1, Tampa.

In our region, because of our knowledge of our particular area, our feeling was that the No. 1 priority project for the medical district should be the clinical addition at Tampa, with the spinal cord injury project. The problem there being that we can't expand any service at Tampa until we first expand in the support areas. That would include a spinal cord injury. It would do us no good to build a spinal cord injury addition without first making sure we could support it within the hospital.

The second, we have the psychiatric beds at Gainesville. That has been a priority for the region ever since I've been in the region, which is now 7 years. As a matter of fact, back in another lifetime, when I worked for Mr. Randall, we planned that unit—the first planning for it began in 1970. We did some very serious planning on it through the mid-1970's, and we're still really not on the boards with it. So that was our second one.

Then comes the West Palm Beach hospital, simply because of the large number of underserved veterans in that area. We have an underserved veterans population in Palm Beach County, and immediate surrounding areas, that's larger than the veterans' population of some States. We have also a priority for a facility in east central Florida to serve the Orlando and the midcoast area. Again, a highly desirable and highly needed facility to reach new veterans here currently underserved.

One of our lower priorities in our arrangement was the nursing home care unit at Lake City, but that is not to say that it isn't needed. Our concern is that when the general public thinks of the aging veteran, they tend to think only of extended care facilities. I think you'll find, if you can look at the literature, that the elderly and the aging patient requires repeated episodes of acute care, and we're very much concerned that we must maintain the acute facilities available for those veterans when they need them, as well as provide the extended.

By the way, I might say that every nursing home that is in the planning for Florida has been redlined, with the exception of the Lake City home.

Senator **Graham**. You indicate that the priority list that you just stated wasn't necessarily the priority list which the Veterans' Administration submitted to OMB as its priority?

Mr. **Thompson**. Yes, that's right.

Senator **Graham**. What was it?

Mr. **Thompson**. Well, the construction people look at various categories of construction and various ways that the construction of dollars is put together and they have a rating and ranking formula that ranks projects. They want to make certain that we fund some of every type. And it just happened that in their ranking, the nursing home came out ahead of ranking. And our Tampa project slipped entirely out of the budget, which I think is a shame.

Senator **Graham**. Mr. Randall, a couple of years ago when I was just beginning my service on this committee, I remember a session that we had in Gainesville, and you described the planning process that had been established, which seemed to be a very thoughtful one. Is this situation in which the planning process from this medical district then gets modified at the Washington level, is that something peculiar to this year, or has that been a recurring pattern?

Mr. **Randall**. That's been a recurring pattern. In this medical district, our No. 1 priority is the psychiatric facility, followed very closely by the clinical addition and SCI unit at Tampa. As Mr. Thompson has indicated, when the regional priorities come forward, these two projects still have high priorities. It's after they get into Washington, and they are melded in with all the other projects across the country that they apparently lose their high priority status.

However, those projects have been in the Agency budget that has gone over to the Office of Management and Budget. And it's there in OMB that they get deleted.

Senator **Graham**. I'm concerned about the fact that we have a planning process at the district level which is intended to establish overall priorities, that then gets substantially mangled as it goes up the chain of command. Is that an accurate statement of what is in fact happening, and if so, what's the rationale of spending a lot of effort in doing the planning at the district level if it's not going to be respected?

Mr. **Randall**. Well, I think, and Don can correct me if I'm wrong on this, one thing that happens is that the Agency has a priority system that assigns points to all the projects in order to keep an objective kind of approach to determining which projects will wind up in the Agency budget. And perhaps that system needs to be examined to see if the priority system being used is still a valid one.

Mr. THOMPSON. Let me just add that perhaps I put more emphasis on that than deserved. What actually happens is the priorities from 27 medical districts come in. The fact that Lake City is in there, it was our fifth priority from our region, but it was our first priority for nursing home, because it was attainable. Now it did end up being the only nursing home, as I recall, in the budget. So, our top priority for nursing home got in.

It's not as if they take them and shake them up and totally rescramble them. I think you could carry a line of reasoning from the hospital to the medical district through the region to the planning process and Washington, and see that the priorities are being recognized. It's just that when you start melding all those priorities together, and since there is a desire to build a few of every type facility, that they don't always come out in exactly the same priority that we may have hoped that they would.

I think some of these people may have had the pleasure of visiting our Tampa hospital. And on a Monday morning there are approximately 750 people walk through the door seeking services. And the hospital was built to accommodate approximately 150 a day. It unfortunately was on the drawing boards prior to the enactment of the legislation that made ambulatory care possible. So it's totally inadequate for the job that it's now being asked to do. So that's why our priorities are there.

But generally speaking, I'd say our planning process is relatively—is very true to our priorities in general. The problem is, they start with a dollar figure that's much less than it takes to meet the need, and some paring has to be done.

Senator GRAHAM. Speaking of that paring, on page 3 of your testimony you state that your fiscal year 1989 funding allocation is insufficient for our medical centers to attain the level of services provided in fiscal year 1988.

Mr. THOMPSON. That's true.

Senator GRAHAM. What would be your estimate of what additional funds, supplemental funds, would be required if ordered to bring you up to your 1988 level?

Mr. THOMPSON. I really can't—I can try to develop that figure for you for the record. I don't have it that precisely. When we talked at the hearings in September, we were talking about a cumulative deficit, or a shortfall that's accrued over the approximately last 3 years. It depends on where you want to count. You could actually go back to fiscal year 1977 and see decrements in inflationary factor that's been applied. But we could attempt to develop that and look closer.

Senator GRAHAM. Mr. Randall, on page 3 of your testimony you state that major operations changes have been implemented that impact on both the inpatient and outpatient program. Would you give us some more elaboration on what changes have occurred?

Mr. RANDALL. Yes, sir.

It has been necessary for us to close inpatient beds simply because we don't have the funds to support all of the operating beds that we have. And we've had to constrain our outpatient workload. We have done this by applying the priority system, so that those with the lowest priorities have been dropped from the outpatient program, or have not been entered into the outpatient program.

Senator **Graham**. There was a news item from the Gainesville Sun, January 25, describing the Veterans' Administration plan to reduce some 70 beds at the Gainesville hospital. Is that news item accurate, and if so, why are we closing beds in Gainesville? Is that a direct result of budget shortfalls?

Mr. **Randall**. Yes, and no, Senator. We closed 40 surgical beds. We closed those because our occupancy rate on surgery had been low enough, and we had sufficient vacant beds on surgery, so that we could consolidate those beds on one fewer ward. So that prudent management would have dictated that we do that even if we didn't have a fund shortfall.

I must say, however, that we do not have the money in our operating budget to reopen those beds should the demand be there today. The other 30 beds which were in the nursing home care unit, are the direct result of funding shortfalls.

Senator **Graham**. When you say, if the demand is there. There is not evidence at the present time to indicate that there is that demand?

Mr. **Randall**. Well, the choke point in our surgical program, in any surgical program is the surgical intensive care unit beds. The number of beds on a ward are not the limiting factor. The limiting factor is the number of operating rooms available, and the number of surgical intensive care unit beds available. So, because of our choke point in SICU beds, we have not been able to admit and provide surgery for the number of patients that we could. We have had a project in for some time now to expand the surgical intensive care unit, but even if those beds were expanded we don't have the money to take care of these additional surgical patients in this fiscal year.

Audience Participant. Senator Graham.

Senator **Graham**. Sir, we are about to get to the point that we're going to have comments from the audience.

We're building an important record for people that aren't as knowledgeable about this as a lot of folks who are here, or who have testified.

Mr. Randall, you state on page 4 that the outpatient workload in Medical District 12 facilities would have grown significantly more if not restrained due to resource limitations. What did you do in order to restrain the growth of those outpatient clinics?

Mr. **Randall**. We started rigidly applying the eligibility priority for patients who either are in the program, or those who were applying for the program. Those who were in the program who had initially been picked up after moving to Florida, who had long-term chronic conditions were dropped from the program. New patients presenting who had moved here from other parts of the country, who were non-service-connected, and who were low on the priority list, were not picked up in the program.

Senator **Graham**. Mr. Randall, do you have any further comment relative to the psychiatric care facility at Gainesville, and its importance?

Mr. **Randall**. It is significant for this medical district. It is a facility that will serve the entire State. I think that Mr. Thompson and the people in the VA have seen the necessity for this. It simply has not been able to be high enough on VA's priority list when OMB reduces the construction budget of VA.

Senator **Graham**. You've mentioned that OMB, and/or the Veterans' Administration has given a generally low priority to nursing home construction. Has there been a similar policy relative to long-term psychiatric facilities?

Mr. **Randall**. No. I think not, Senator. I don't think that has specifically been addressed by the VA or by OMB.

Mr. **Thompson**. I don't believe there's been a conscious decision to do that. In the last few years, however, most of the hospitals that we've activated and the units we've activated have been general psychiatric care as opposed to specific allowances for long-term care. And perhaps it's just something different enough that it hasn't come up. It is larger than most units that are being established.

But the need is clear. At one point in time we were planning on the basis of a need for approximately 700. Even if we get the unit, which I think we desperately need, we will still be short of national average figures for the long-term care site. We have created small units at Dublin, Georgia, Lake City, Bay Pines, and Miami to help offset some of the load. But those are usually one ward stop-gap type arrangements. But they do help.

Senator **Graham**. Mr. Thompson, Mr. Randall, I thank you very much for your very helpful testimony. [Applause.]

Members of the audience, first for those of you who would like to direct any comments or questions to our office, I would like to give you the address. It is 241 Dirksen Senate Office Building, in Washington, 20510.

At this time we have approximately 30 minutes for any comments.

Mr. **Farnum**. My name is Angus Farnum, from the Paralyzed Veterans of America of the Gulf Coast Chapter, Tampa.

Senator **Graham**. I would also like to ask if we could have the name and address of each speaker written so that we can help in the transcription process.

Yes, sir.

Mr. **Farnum**. My home address is 8785 56th Street North, Pinellas Park, FL 34666.

We deal with very severely handicapped individual veterans, and space available for treatment right now at the VA hospital in Tampa is very limited. The shower facilities on the SCI ward are being used for storage. Certain training is being done in the rooms, and I feel that this is an issue that definitely needs to be faced and addressed. I feel that the issue of construction, which has been sliding back since 1985, needs to be put back on line as fast as possible to get this taken care of.

The issue of suppression of veterans trying to receive treatment, I see this quite a bit because I also volunteer as a veteran at Bay Pines in St. Petersburg. When I'm there, I see veterans come in for treatment and they're told that they can be treated once, if it doesn't work, they can't come back, because they're only treating one time on a mean's test. If they do come back, they have to be first released from treatment and then come back and reapply.

I think this is both a waste of time on the veterans part because he needs medical care, and also on the VA's part for all the paperwork and all the checking out that has to be done in order to see if a veteran, again, is eligible for treatment.

The third concern would be the way that a lot of veterans feel that they are not getting a fair shake. They did defend this country in many different ways and are now being turned away, being told that they can't get treatment because they're not service connected, or they're not eligible due to monetary values. Medical treatment of veterans needed is the issue. And if it costs an extra $5 billion a year, then the Veterans' Administration or the Department of Veterans Affairs should get it. That should be one of the first priorities of this country to turn around and take care of the veterans that took care of this country. Thank you. [Applause.]

Senator **Graham**. Thank you.

We have approximately 10 to 12 people who are standing in line to speak and we have about a little less than half an hour, so I'm going to enforce a fairly strict 2-minute rule on each person. OK? So if everyone would be prepared to say what they wish to express in 2 minutes.

We'll start on the left side. Yes, sir.

In order to save time, since we're going to be taking names and addresses on the pad, we can dispense, other than stating your name, with further identification.

Mr. **Grassa**. My name is Hal Grassa. I've been into five VA hospitals, Vermont, Massachusetts, Pennsylvania, and Florida here. Now, I've been to the VA clinic and I have been refused medication that I need for circulation in my blood. I have 80- to 90-percent blockage and I told them that, and you know what they tell me? They said we can't issue these pills because the Reagan administration in Tampa will not give them money to buy these pills. Now, I have to take almost $90 out of my 100 percent to pay for medication that I need. Now, can you tell me if the Reagan administration has given those orders to Tampa?

Senator **Graham**. Mr. Thompson or Mr. Randall, would you care to comment on that?

Mr. **Thompson**. No such order.

Senator **Graham**. No such order has been directed.

Mr. **Grassa**. Well, why can't they give them to me?

Senator **Graham**. What I'd like to do, sir, on specific cases like this, we would like to have your experience submitted to the committee, then I would like one of the persons who is here either from the VA or from our staff to meet with you and try to see if we can find out what will be required to solve your specific problem.

Mr. **Grassa**. Now, I've been paying this for a whole year. And all they tell me, Tampa will not issue them because the administration said no, no money.

I thank you.

Senator **Graham**. Thank you, sir.

Yes, sir.

Mr. **Thrall**. My name is Mike Thrall, and I want to just briefly touch on some of the issues that I think were brought up, but I'm going to give you a little more personal view.

One of the subjects is physician care. I'm sure that every veteran in this room will support me when I tell you that we've seen the number of qualified doctors in the clinics and the hospitals greatly reduced, and they're often replaced by what they call physician assistants. Many of us refer to them as nondoctor doctors, because you talk to them and they're not doctors, they don't claim to be doctors. What they do is they do the best they can to help dispense some pills. They determine what they think is the illness and then they go usually to a senior doctor, who in most cases probably should be retired, and he sits there and signs forms all day. You never see the doctor-doctor, you're treated by nondoctor doctors. That's an important issue that's not been raised in this room today.

Another point that I think is important, the VA trains, especially in hospitals, they train specialists who come in from the private sector, they do a period of training under—usually in conjunction with the colleges and universities that are adjacent to the VA facilities. They get an advanced degree in a specialty, using the VA patients as their subjects for study, and as soon as they develop their skills, they move out of the VA system. So there's nobody there to carry on the knowledge that they need. It's a well-known problem in the VA medical system, and I didn't hear anybody address that issue.

A concern that I became very much aware of last year during two hospitalizations that I had during 1988, were on two occasions I had young student doctors—this was at the Tampa hospital, who were student doctors from the college across the street, tell me that they spent about a quarter of their time filling out paperwork to document and cover up mistakes they had made. Now, this tells me that our State is taking the finest lives that we have, putting them in medical schools, and they're learning several things. They're learning that the system, anything that has to do with Government medicines, does not work, that it's OK to lie and cheat and deceive the system in order to protect either themselves or somebody else within the system. And it's no surprise that once they get out in the private sector, they join the AMA and the other support groups that support the medical community, that they're against Government medicine. They're against Government health insurance. They're against anything to do with the Government because the exposure they had as students was corrupt and dishonest and didn't work. And I would think that the Board of Regents in the State of Florida ought to look into that.

Senator GRAHAM. Thank you, sir. Your time has expired. If you have any further comments you can submit them in writing.

Mr. THRALL. Thank you for your time, sir.

Senator GRAHAM. Thank you, sir.

Mr. HITCHCOCK. Senator, I'm Wayne Hitchcock with American ex-prisoners of war, an immediate Past President of the State Department, and now I'm a national director, but I want to thank you for this meeting. We didn't have a statement of our own today, but we'd like to have a statement later on——

Senator GRAHAM. Very good, sir.

Mr. HITCHCOCK. And we do concur with the other veterans' groups as I'm sure that American ex-prisoners of war is a member of one or more of these groups.

And what I would like to do, I would like to address one subject in maybe just a few words. I want to thank you at this time, incidentally, for presenting the S. 9, the conclusion of that bill and your part that you played in that law.

But I wanted to address what Mr. Randall mentioned that some of us had lost some of our priority. We ended up in category B in Public Law 100-203, which says we may not be treated. And we feel we should be put back in category A, where it says we shall be treated. [Applause.]

Thank you very much and we will get a statement to you.

[The prepared statement of Mr. Hitchcock appears on p. 123.]

Senator **Graham**. Thank you very much, sir.

Mr. **Hammond**. People have asked a lot of questions about suppression of the applications of VA veterans. I put in an application 5½ weeks ago for posttraumatic stress disorder. My point is, I went to the VA clinic several times for treatment, I was disallowed because I didn't have a disability rating. Now, this has taken a long, long time and I feel that perhaps I'm nearer to it now than I ever was, but the problem of getting in for treatment with a rating, and you don't get treated without a rating. I did have a service-connected disability, but that's not what the posttraumatic stress is for.

So if you could do something about the slow process, I for one would appreciate it.

Senator **Graham**. Thank you very much, sir. If you would contact my staff. Thank you, sir.

Mr. **Maglio**. Thank you for letting me speak. My name is John Maglio, and had surgery back in 1987 in a private hospital. I went back to the VA and it was 7 months before I had my first blood test after the operation. Not knowing what to do, what kind of diet to go on, I developed sugar diabetes. And not only that, I was stuck with a $36,000 hospital bill. I'm a 100 percent disabled veteran. My wife went over and applied to the VA. It was an emergency. I had four by-passes. Whoever my wife talked to on Saturday did not notify the VA on Monday because they did not know that I was in that hospital until the 27th of January and I went there on the 17th. I had an appeal to the kangaroo court. I've been in this system for 43 years, but this is something new here. I understand as much as I'm supposed to understand. And I think it's unjustifiable to be charging me and many other veterans like me $36,000.

That's it.

Senator **Graham**. Thank you very much.

Ms. **LaMarra**. Good afternoon, Senator Graham. I'm a veteran and also I've served in three wars. My main concern is for the veteran health needs in central Florida. Now we have a very inadequate facility here in the outpatient clinic. They try their best, but it's not enough. We are in dire need of a general veterans' hospital here in this area.

Therefore, if the plannings are such that they plan to have a psychiatric hospital in Gainesville, why not give us a hospital, a much needed hospital in this area for our veterans. They could put an extension to that hospital, that is a general hospital, put an addition to the general hospital of a psychiatric hospital, and use the staff facilities for both, such as your x ray, your laboratories, and your diet, kitchens, and so forth. We really need it. And my question to you, if you would take that issue into serious consideration.

And another thing I wanted to ask you, is it possible to bill the other Veterans' Administrations in other States the cost of the care that their veterans get when they come here. If that's possible?

Senator **Graham**. That second question, I think is a very significant one before us. We are paying the cost of many veterans here on a temporary basis. No. 2, as to a veterans' facility in east central Florida, after the new facility is underway in Palm Beach County, there is high priority for a new veterans' facility in east central Florida and it will be a priority for the coming years.

Mr. **LaMarra**. Thank you, sir. And I appreciate what you're doing for us. Thank you.

Senator **Graham**. Yes, sir.

Mr. **Goetz**. Good afternoon, Senator. I'm S. Sgt. Jules Goetz of the U.S. Army, retired, and the central Florida representative for the Employment Service of Disabled Retirees.

We have heard from all the major veterans' groups here today, and now I'd like you to hear from the smallest. We are service-connected disabled military retirees. As career professionals, we have become the favorite whipping boy of the Office of Management and Budget and the Congress. During the 1950's and the 1960's career professionals were promised as part of their retirement benefits, free medical care. This is not available anywhere in the State of Florida. CHAMPUS is a very poor system. In the State of Florida, there's practically nothing. Doctors and hospitals constantly overcharge the Government, and the Government handles this problem by penalizing the retirees by making them pay the overcharge.

On behalf of the enlisted military retirees, we would like for you to propose legislation to upgrade our health care to the level of our Nation's welfare recipients, by placing military retirees on Medicaid. This way we could get all the required treatment we needed. [Laughter.]

Also, we would like to be considered and treated as veterans. I feel we earned this designation. Presently we are forced by an 1890 law to pay our own veterans' compensation. During the 100th Congress over 90 percent of the Florida congressional delegation supported H.R. 303. You refused to support this legislation in the Senate. As of yesterday, 204 Members of the Congress cosponsored H.R. 303. I wrote your office on this issue 6 weeks ago. Presently 14 members of the Florida delegation are cosponsors of H.R. 303. The Senate version of this bill is S. 190, and the disabled military retirees want and need your support of this legislation. Presently your office should be receiving mailgrams from the National Veterans Council pertaining to the President's 1990 budget whereupon military retirees are again not veterans.

We are veterans, and we want to be considered as veterans by the Congress, even if it takes legislation to accomplish this. Thank you. [Applause.]

Mr. **Windham**. Senator, my name is Steve Windham. I'm executive director of the local health council in east central Florida. I have a masters degree in public health, and I've been involved in health planning in this four-county region, which includes Orange, Osceola, Seminole, and Brevard, since the turn of this decade.

I am here to express my opinion to urge you to really consider the concept of contracting for services, particularly for inpatient care for veterans. When I first got involved in health planning, inpatient hospitals in this area were running at approximately 80 percent. Last year, calendar year 1988, the acute care inpatient occupancy of hospitals in this four-county area was 55 percent. That means that on an average day last year, there were 10,600 plus beds empty in these four counties.

If you put this in perspective, on an average day if you put all these hospital beds together, you could build a hospital that would be the size of Orlando Regional Medical Center. That's how many inpatient acute care beds there are. Now, I'm not a real shrewd businessman, but I would say if you could manage it, there is an opportunity for the Government to contract for services. And given the effects of health maintenance organizations that are currently dealing with the hospitals on cutting deals for inpatient services, I would say the Federal Government should investigate the opportunity as much as possible.

I tend to be dealing with planning for services with funds—I urge you to put money into those services that are most needed to help patient services as much as possible, such as primary care.

I could go on, but I'll stop there. [Applause.]

Mr. **Gallagher**. My name is Larry Gallagher and I'm the local commander and first director of Veterans of Foreign Wars from 1981 to 1989. I'm also a 40-percent disabled veteran of World War II, and I'm over 65 years of age.

A year ago I went to the VA facility in Gainesville, where I had been a patient years ago and received excellent care, and the people were very dedicated workers. I don't know how we get some people that are so dedicated in serving veterans. They should certainly be commended, because they are workers. But this last time I went out there for what I thought was part of my service connection, but when they took x rays and so forth and so on, gave me treatment, I was informed, don't bother coming back, we will not take care of you.

Now, if a 40 percent disabled veteran with service connection and over 65 years of age cannot get treatment at a VA facility, what does the poor veteran get who has no service connection, other than the fact that he's an honorably discharged veteran. These people, in my opinion, are entitled to free medical care at the VA facility, and I would like to see that reinstated. It was guaranteed by one of our famous Presidents, that when you reach 65, you would be entitled to free medical care at the VA facility. I'd like to see that done again. [Applause.]

Senator Graham, I appreciate your coming and doing this for our veterans. Thank you. [Applause.]

Mr. **Shea**. Senator Graham, my name is John Shea. There were two speakers prior to me—I'd like to amplify on what each of them said.

The young lady here dressed in blue talked about the VA clinic here in Orlando, and the lack of a hospital in this east central part area. I listened to Mr. Randall and Mr. Thompson speak about conditions of the Tampa hospital and the Gainesville hospital, one for a psychiatric unit and the other a clinic. In the meantime there is no hospital, period, here in this east central area. And I think that speaking for the thousands of veterans here in Orlando, but more so over on the east coast, there is a vital need for a hospital facility, more so than a psychiatric clinic or additional clinics over in Tampa. For the time being, we from the east coast have to travel, for a VA clinic, we have to come to Orlando or for hospital care, all the way over to Tampa. It is inconvenient.

The gentleman preceding me spoke about the civilian hospitals here in the area, but one of your panel members spoke about the undermining of the VA system if we were to continually avail ourselves of the civilian hospitals. It looks to me that it would be detrimental to the VA system. And I am a firm believer in the VA system and would like it continued. I would much prefer VA care than civilian care.

Thank you very much. [Applause.]

Senator GRAHAM. I would like to thank all those that have spoken and also for the timeliness of their remarks. We are under an obligation to begin to clear this room at 1 o'clock, so we have time, I think, to hear from all the people who are currently waiting in line.

Yes, sir.

AUDIENCE PARTICIPANT. Thank you, Senator Graham, for holding this hearing. As pointed out by some of your panel members, the difficulty is getting into the system. Once you get into the system, you can usually get some treatment. You'll get appointments, but I found that the service was very good once you got into the system. As a patient at Bay Pines twice in the last 3 years, I found the service and care to be extremely good and I had no problems whatsoever. The only problem I've had is that sometimes the medicine as prescribed by the doctors was not available and there was a wait and see. But overall, I feel that the Veterans' Administration hospitals take care of veterans very well.

Senator GRAHAM. Thank you.

Yes, sir.

Mr. FABREGAS. My name is Bill Fabregas. I'm sure you're aware the DAV is a very service oriented, dedicated service group, and I picked up on one of your remarks in your opening statement that there may be some funding coming to Florida. You know, we make this promise of adequate care to our wartime disabled, widows, and orphans. It's pretty hard to say possibly, or maybe, adequate. We have to guarantee with a clear conscience that these people are going to get the adequate care that we promised them.

Now, Senator, only you and your constituents from the State of Florida in Washington, can go to work and get us this adequate care that we not only want, but we need to live up to the promises that we made to our disabled and widows. And I don't feel that when we say it may be on the way, is enough. That's like saying—I feel that when you go back and you sit with your constituents you should sit down and reevaluate what's been said here today from the people that you've heard from and say, it will be on the way, so we don't have to give these people a definite maybe. We can give them a definite yes.

Thank you, Senator, for your time. [Applause.]

Senator GRAHAM. Yes, sir.

Mr. RAWLE. Senator Graham, my name is William Rawle. I went up to Gainesville hospital and I had an appointment with a secretary for something that had been dropped into my records, and I've been waiting for 6 months trying to get a hearing to explain my side. I like the way the gentleman said on the last panel here, that on a low priority you can't get a hearing——

Senator GRAHAM. If you would just see Mr. Randall, and he would like to talk to you about your specific situation. He's the head of the VA hospital in Gainesville.

Mr. RAWLE. OK.

Another thing, I've been a resident here for 5 years, before I had been treated at Haines Hospital in Waynes, IL, and they sent a letter down here asking if they would treat me for an ailment they were treating me for 9 years. They treated me four times here, and after four times they told me there was a shortage of money from the President and that they had to drop me here. Now I have to commute 100 miles or 2,500 miles, and they better do it, because four times year, at 2,500 miles I can only do it once a year. So as the other gentleman said, they should see these people and they're not seeing them.

So I figured that if I have to go 2,500 miles they should be able to treat you here. That's all.

Senator GRAHAM. Thank you, sir. If you would see Mr. Randall. He's right there behind you.

Mr. COLLINS. My name is Willie Collins, and I'd like to comment on the care of PTSD patients in Florida hospitals. Right now they have a facility down at Bay Pines, but if you look at the records, most patients from Florida go up to Augusta in Georgia, because—the care in the State of Florida is nothing special as other States. Because here, when you go in PTSD, you go back to the vet centers. There's not enough beds here. And we have to go all over the country for the care. Other States have specialized PTSD, why can't we have enough beds in this State to take care of our own?

Thank you.

Senator GRAHAM. Thank you very much.

Yes, sir.

Mr. JAMES. John James, sir, from Orlando. And I'll make this real short. We've heard so much about the lack of funds, I have a suggestion that will certainly help the VA reclaim some of those funds and not waste so much money anyway. I retired 1968, Air Force, and I had my retirement physical at Patterson Air Force Base, and the paperwork I received said I had a 60 percent disability for hypertension and arthritis. After 21 years, now since I had my physical, I was told by the VA 3 months ago, here, that I have a—disability, because I never filed a claim, a disability claim with the VA. I never filed it because I was never told to file it.

Now, why can't each military retiree, Navy, Army, Coast Guard, what-have-you, when he gets his retirement physical, why doesn't a copy of that go to the VA. The VA wouldn't have to give another evaluation for the disablement. And I think some money could be saved there. And I've waited 3 months now for surgery on my wrist, because I had a—disability.

Thank you for your time.

Senator GRAHAM. Thank you very much. That seems like an eminently reasonable suggestion. Thank you, sir.

We are now at the hour of 1 o'clock, and we've got two more folks who've indicated they'd like to speak, so we'll hear from them.

Mr. HOLLOWAY. My name is Bob Holloway. I work for the Labor Veterans Employment Training. And on a day-to-day basis I see veterans who ask if they're in suppression because they didn't go to the VA. Yes, it happens. We've got veterans that should have medical care. Last month I had a guy come into my office, he was eating out of garbage cans. He had loose bowels, and almost fainted on the chair. He couldn't hear and the Lions Club bought him a hearing aid. He couldn't see. The Lions Club paid for glasses.

This is just to reinforce, yes they are suppressions. It's too far away, or they can't get anything, they're ashamed, they're concentration on staying for 2 or 3 hours sometimes just isn't there.

Senator GRAHAM. Thank you, sir.

You will be the concluding speaker for our program.

AUDIENCE PARTICIPANT. Senator Graham, technically I'm not supposed to be here, according to Washington's standards, I'm not a veteran. I'm a retiree with 33 years service. [Laughter.]

It rubs me the wrong way. In fact I wrote to your office a month ago about this. I feel that I'm a veteran as much as anyone else in here, but I can't belong to these organizations because I'm not a veteran, I'm a retiree, sir. The cost-of-living increase that we were told as retirees we're not going to get this year, but the veterans' organizations aren't going to be reduced financially in any way, shape, or form.

I'd like to know just where I and other people in my category fit into the picture. A few years ago they changed the retirement system, and at that time they told us we'd be grandfathered in. It wouldn't affect people who were going into the service at that time, or those who had previously retired. Now, they're changing the rules again. And I think with 33 years service, I should be a veteran.

Also, because they did say we'd be grandfathered in with cost-of-living increases, that Washington should live up to that.

Senator GRAHAM. Sir, I agree—I could not agree more strongly. I think that the Federal Government has a contract with the systems for Social Security, and has an equal contract with its veterans that serve this Nation, and that contract calls for us to keep their benefits at the cost of living that they anticipate. And I, for one, will work to see that that contract is fulfilled.

AUDIENCE PARTICIPANT. You just answered my question.

Thank you.

Senator GRAHAM. Thank you. [Applause.]

Ladies and gentlemen, I want to thank you very much for what has been an extremely informative session from all the participants here today. I assure you that it will be read and it will be an important part of the Senate's deliberations when we review our future policy as it relates to veterans' health care.

Thank you for giving us such an important contribution. [Applause.]

This hearing is adjourned.

[Whereupon, at 1:04 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

[From the Gainesville Sun, Jan. 25, 1989]

VA PLANS TO CUT 41 JOBS, 70 BEDS

(By Jud Magrin)

The Veterans Administration Medical Center in Gainesville is eliminating 70 beds—40 surgical beds and 30 nursing center beds—which will result in 41 jobs being phased out, according to Director Malcolm Randall.

Randall said the combination of increased costs and lower occupancy rates at the hospital caused him to eliminate 40 surgical beds and the positions that staff those 40 beds. As people leave those positions, the jobs will not be filled. The move will take the VA hospital's bed count from 473 to 433, he said. Beds at the nursing center are not included in the hospital total.

But Gladys Caracci, president of the local chapter of American Federation of Government Employees and an employee in the hospital's Medical Administration Service, opposes the move. The union represents 27 of the 41 affected employees and has a total of 500 local members, she said.

"It's poor management of funds," Caracci said. "We have lost 41 jobs in the last week due to bed-census loss. It is beyond me how you call it a bed-census loss when we have a tremendous waiting list (for surgery and the nursing center)," Caracci said.

The issue has caught the eye of John Sturdivant, national president of the union. He planned to meet with Randall at 9:30 a.m. today and then with the employees. He was unavailable for comment Tuesday.

Although the hospital's budget grew from $83.8 million in 1988 to $84.4 million this year, Randall said, costs have outpaced the relatively modest budget increase.

He said the money is not enough to maintain the same level of service as in 1988, and "the hospital-occupancy rate has not been sufficient to utilize all the hospital beds and so we are consolidating those beds."

Randall said occupancy rates at the VA were 77.8 percent in 1987, 75.2 percent in 1988 and is running at 67 percent for the first quarter of 1989. "It doesn't make sense to staff empty beds," he said.

Caracci said it doesn't make sense to have empty beds when there is a waiting list of people in need of surgery.

She said Randall should have requested more money from the federal government to beef up his budget. "Had this been a football team, they would fire the coach," Caracci said. "He has not asked for the accurate amount of money.

"The waiting list is tremendous. The only reason we have empty beds is because our budget was cut. There is not enough employees in the operating room or time budgeted for the operating room," Caracci said.

But testimony before U.S. House and Senate committees revealed that there was a $600 million shortfall nationwide for VA hospitals, Randall said. The 30-bed cut in the nursing center is also because of a lack of money, and "we also need to change our mix of patients so that we have the opportunity to rehabilitate some patients," he said.

Randall said there are two reasons for the empty hospital beds, and he didn't deny that there may be a waiting list for certain surgical procedures. He said patients are operated on and moved out of the hospital as soon as possible and often the surgical intensive care unit is full. Randall said you can't put a patient in a surgical bed if there is no room in the intensive care unit for recovery.

He said the hospital continues to meet its mandated task of caring for those people who have illnesses or were injured in the armed forces.

"It is our hope to reopen" these beds in the future, Randall said.

[From The Orlando Sentinel, Mar. 24, 1989]

VETERANS BLAST LACK OF MEDICAL CARE

SPEAKERS TELL GRAHAM OF LIMITED ACCESS TO DOCTORS, HOSPITAL CARE

(By Michael Griffin)

Florida's veterans are getting a raw deal from Uncle Sam as thousands of former servicemen and women lack basic medical care, a U.S. Senate committee heard Thursday in Orlando.

Sen. Bob Graham, D-Fla., convened the meeting to hear testimony from veterans and health-care groups about the availability of medical care for veterans. The three-hour hearing was often emotional as veterans talked of waiting months to get checkups.

"Every day of procrastination by Congress is costing Florida veterans their lives," said Robert Jackson, state legislative director for the American Legion. "Florida's veterans have the worst access to medical care than any other VA district in this country."

Others testified that veterans must wait as long as three months for heart exams and up to eight months for eye exams.

Jackson and nine other witnesses told Graham that although Florida's veteran population is growing by 5,000 per month, the state's share of Federal Veteran Administration funding has not even kept pace with inflation.

Graham, a member of the Senate's Veterans Affairs Committee, said this year's budget for veterans medical care has a deficit of $635 million. Because of its population growth, Florida's 1.5 million veterans will be hit hardest by the shortage, he said.

Graham and 40 other senators have asked President Bush to give the VA an emergency appropriation of $618 million, but the senator added that much of the problem hinges on Congress.

Congress has been unwilling to cut funding to Rust Belt states that are losing veterans and increase funding to Sun Belt states that are gaining them, Graham said.

"The political reality is that members of Congress are unwilling to shut down [VA] hospitals with empty beds in their districts," Graham said.

There are 27 VA medical districts in the United States. Medical District 12 includes 19 counties in south Georgia and most of Florida. But while District 12's veteran population has surged, the number of hospital beds has been reduced because there isn't enough money to hire nurses, doctors and others.

The most severe problem could be the lack of care for veterans with mental health problems. Graham said he will push to open in Gainesville a long-term psychiatric care hospital—a facility that has been cut from the federal budget every year since it was first proposed in 1974. District 12 is the only one in the country without such a facility.

Donald Thompson, director of the southeast region of the Veterans Health Services and Research Administration, told Graham of other Florida priorities that have been cut in recent years:

A spinal cord unit for the VA hospital in Tampa to treat disabled veterans.

Expanding the VA hospital in West Palm Beach.

Building a new hospital in east Central Florida.

Building a veterans nursing home in Plant City.

Thompson said veterans receive quality health care in Florida, but that care is "rationed out because we just don't have the staff."

State Rep. Alzo Reddick, D-Orlando, told Graham that veterans are forced to seek either from state welfare agencies or private hospitals, thus putting a strain on Florida's entire medical system.

Al Linden, of the Florida chapter of Disabled American Veterans, said veterans are forced to see private doctors and spend savings because they can't get into the district's five medical centers.

Angus Farnum, national director of the Florida Gulf Coast Paralyzed Veterans Association, said veterans deserve better treatment.

"Veterans don't feel they are getting a fair shake. If it costs an extra $5 billion to fund medical needs then they should get it," Farnum said. "Take care of the veterans that took care of this country."

STATEMENT OF SENATOR FRANK H. MURKOWSKI (R-AK) DURING THE COMMITTEE ON VETERANS' AFFAIRS FIELD HEARING, ORLANDO, FLORIDA

I regret that I was unable to attend today's hearing. I commend my friend from Florida, Senator Bob Graham, for his interest in veterans' health-care issues and for holding this important hearing.

First, there is good news to report. It is my understanding that President Bush will be sending to the Congress a fiscal year 1989 supplemental funding request for VA medical care of about $300 million. The new Secretary of the VA, Mr. Derwinski, worked diligently to obtain these additional funds. I am pleased that he was successful.

When we consider the needs of veterans -- including those who reside in the State of Florida -- we must keep in mind the fiscal crisis facing our Nation. This crisis is the Federal deficit. I have stated on many occasions that the most generous system of veterans' benefits will have no value if the economy that supports it is crippled by a crushing burden of Federal debt.

The Members of the Committee on Veterans' Affairs agree that if the VA is to continue to operate as they have in the past, more money is needed. But I believe that we cannot afford to continue business as usual. We cannot do all things for all veterans.

I APPRECIATE THE FRUSTRATION EXPRESSED BY MANY OF THE WITNESSES REGARDING THE AVAILABILITY OF VA HEALTH-CARE SERVICES IN FLORIDA. WE KNOW THAT THE VETERAN POPULATION IN FLORIDA IS GROWING AND WILL REACH 1.5 MILLION BY THE YEAR 2000. WE ALSO KNOW THAT THE VETERAN POPULATION IN GENERAL IS AGING. BY THE YEAR 2000, 9 MILLION VETERANS WILL BE AGE 65 OR OLDER.

THE VA IS CURRENTLY PLANNING FOR THE CONSTRUCTION OF TWO NEW HOSPITALS IN FLORIDA TO BE LOCATED IN WEST PALM BEACH AND EAST CENTRAL FLORIDA. MY CONCERN IS THAT THE VA'S BUDGET IS NOT GROWING SUFFICIENTLY TO ACCOMMODATE THE OPERATING COST OF THESE NEW FACILITIES. WE HAVE RECENTLY LEARNED OF NEW FACILITIES WHICH CANNOT OPEN DUE TO LACK OF EQUIPMENT OR STAFF. IF WE CANNOT ADEQUATELY FUND THE HOSPITALS THAT WE HAVE, WE SHOULD NOT CONSTRUCT NEW ONES.

IN THIS REGARD, THE CONGRESS AND THE VA MUST BE WILLING TO MAKE DIFFICULT RESOURCE ALLOCATION DECISIONS. WE MUST BE WILLING TO TAKE A HARD LOOK AT THE NEED, ROLE, AND MISSION OF EVERY VA FACILITY. IN SOME CASES, CONSOLIDATION, MISSION CHANGES, OR CLOSURE OF VA FACILITIES ARE NEEDED. IT WILL NOT BE EASY TO IMPLEMENT NEEDED CHANGES IN THE VA SYSTEM, BUT IT CERTAINLY MUST BE DONE.

I LOOK FORWARD TO WORKING WITH THE COMMITTEE MEMBERS -- AND ESPECIALLY MY DISTINGUISHED COLLEAGUE SENATOR GRAHAM -- ON THE MANY CHALLENGES WHICH FACE THE NEW DEPARTMENT OF VETERANS AFFAIRS.

THANK YOU, MR. CHAIRMAN.

Written Testimony from Representative Alzo J. Reddick, 40th District, Orlando, Florida to the United States Senate Committee on Veterans' Affairs. (Presented at the March 6, 1989 Committee Meeting).

Good morning. Thank you for allowing me the opportunity to provide your committee with written testimony regarding urgent issues affecting Florida's veteran population.

As Chairman of the Florida House of Representatives Emergency Preparedness, Military & Veterans Affairs Committee, I feel compelled to share my thoughts regarding what I consider the federal government's inequitable treatment of veterans in Florida.

As you know, Florida has the distinct honor of having the fastest growing veteran population among large states in the nation, totalling approximately 1.5 million.

During the decade of the 70's, Florida's population of military veterans increased by 43.3% -- the largest such increase in the nation. This mammoth growth has sustained throughout the 1980's, and is expected to continue until the end of the century.

In addition to experiencing a bigger surge in veteran population growth than any other large state in the nation, Florida boasts the highest incidence of veterans per general population of any large state except Pennsylvania (16.19% of all age 17 and older Floridians are veterans, as compared to 16.64% in Pennsylvania).

By contrast, most other states are actually losing veterans, and rather quickly I might add.

Certain demographics of the Florida veteran population are of particular significance and concern:

- o Florida is home to the oldest median age veteran population in the nation
- o Florida has both the highest incidence of service connected disabled veterans and the most seriously disabled veteran population in the United States

Much of this is attributed to our inordinately large proportions of World War I and World War II veterans, coupled with the fact that Florida is home to both the 4th largest populations of Korean and Vietnam Era veterans, as well.

In view of Florida's obvious bulging veteran population and its resulting deficits, the federal government, principally the VA, has been extremely slow to react appropriately.

For example, with its extremely

high percentage of disabled veterans (over 12% of the total veteran population), and highest level of average disability ratings, FLORIDA IS ALSO THE LOCATION WHERE VA HEALTH CARE IS LEAST AVAILABLE.

Although federal expenditures on Florida veterans and their dependents total well over $3 billion annually and over $2 billion in VA guaranteed home loans, more veterans are denied VA health care in Florida than anywhere else in the nation.

If only "average" access was provided to VA health care in Florida, the Commission on Veterans Affairs estimates that additional care received would be worth approximately $160 million each year.

To put this another way, while veterans are consistently moving to Florida from other states across the nation, health care dollars appropriated by Congress are not following them.

For reasons beyond my ability to comprehend, the money continues to go to the states the veterans are leaving.

If the money was following the veteran, as it logically should, we would automatically be entitled to a much more significant piece of the pie for our veteran population; to the tune of AT LEAST an additional $160 million.

I sincerely feel the provision of adequate health care services to Florida's veterans is not only the right thing to do, it is the cost effective and economically sound thing to do.

If it's cost effective for the general population to practice preventive health care, then why in the world would it not be beneficial for veterans to have a system which facilitates preventive health care as well?

Although I consider resource allocation failures by the VA to be disgraceful and rather tragic for

Florida's veteran population, there are other rather serious problem areas:

The VA Regional Office (VARO) in St. Petersburg is a prime example: VARO is the centralized processing point of all applications for VA benefits.

While Florida has emerged as the only large state with rapid growth in its veteran population, it also has experienced one of the most pronounced reductions in terms of VA workers. These manpower shortages arguably have numerous implications:

- Florida has the busiest VARO in the nation in terms of applications processed per worker
- Florida has the largest number of claims denied
- Appeals to the Veterans Appeals Board are twice as numerous

Perhaps the most critical issues facing Florida and its rapidly growing veteran population relate to securing adequate federal resources to meet the escalating, well documented needs.

As a state representative, I can only bring these discrepancies to your attention.

It's up to you to make sure the remainder of your congressional counterparts hear, understand, develop an appropriate level of sensitivity to, then ACT accordingly to RIGHT these devastating WRONGS which Florida's veteran population have had to live with.

Please allow me to share with you a Resolution being sent forth in the Florida House of Representatives, which I hope will eventually become a Joint Resolution and be forwarded to you under official seal.

This document depicts the growing concern of the Emergency Preparedness, Military & Veterans Affairs Committee for the serious lack of adequate health care services for Florida's veterans.

It is my hope this testimony will serve to raise the level of sensitivity to Florida's problems in this regard, and become the catalyst for continued communication between your committee and Florida's legislative committees handling veterans issues.

In conclusion, veterans have a right to expect, at a bare minimum, quality health care, accurate and prompt processing of their claims for benefits, and reasonably efficient delivery of those benefits they are ENTITLED to.

We cannot stand by and allow a system to continue to flourish which rations services to the honorable men and women who served in defense of their country.

While other federal program budgets are increasing, VA budgets are falling further and further behind inflation.

Since 1985, Medicaid spending has grown by 55% and Medicare spending is up 32%. Spending for veterans health care has increased by only 17% over the same period, and Florida's share falls tragically behind that percentage growth.

Since 1980, VA patient workloads have increased substantially -- hospital patients, up 7%; outpatient visits, up 29%; veterans receiving VA-paid nursing home care, up 63%. However, the VA's medical budget has increased by only $400 million in real dollars during this period.

With such a gloomy picture at the national level, there's little hope for a brighter future in Florida for veterans.

However, in spite of the predicted VA medical funding shortfall I keep reading about, a more appropriate allocation of available funds would give me a reason to celebrate.

Because Congress has undertaken the admirable and necessary chore of reducing the federal deficit, congressmen across the nation will be forced to review the entire budget structure with an eye for development of a more efficient, more justifiable system.

You have a responsibility and a perfect opportunity to make it known to any and everyone who will listen that the present system of allocation of VA health care dollars is grossly unfair and perpetuates sub-standard treatment of veterans in growth states like Florida.

Common occurrences such as staff shortages; termination of services; more and more veterans standing in line for, only to be turned away from needed medical treatment; veterans traveling hundreds of unnecessary miles just to receive basic medical care; are all examples of deplorable practices veterans have grown accustomed to in Florida.

All of which something can be done about, I might add.

THIS IS WRONG! Something CAN AND MUST be done to alleviate such conditions, in spite of projected funding shortfalls.

Now more than ever before, your committee must look at resource allocation very critically, and do the RIGHT THING, which is to provide quality care for our veteran population, regardless of the state they choose to reside.

While I applaud Secretary-Designate of Veterans' Affairs Edward Derwinski's efforts to secure a supplemental appropriation and additional staff for the federal veterans program, unless you make sure every state is treated fairly and equitably in the distribution of funds, Florida will fare no better proportionately than it is now.

Thank you for allowing me the opportunity to present this written testimony and accompanying Resolution.

Thank you for taking the time out of your busy schedules to hold field hearings on this extremely important issue.

And thank you for caring enough about those who have risked their lives so that we might have the freedom to realize our dreams, to do your part in MAKING A DIFFERENCE FOR FLORIDA'S VETERANS!

Please contact me at (904) 488-0760 if you wish to discuss this critical matter further.

I assure you I will do all that is within my power to make this a better state for veterans to live out the remainder of their lives in.

Alzo J. Reddick, State Representative
40th District, Orlando Florida

Prepared Testimony of

Major General Earl Peck, Executive Director

Florida Department of Veterans' Affairs

Before Field Hearings of the

United States Senate Committee on Veterans' Affairs

March 23, 1989
Orlando, Florida

US Senate Veterans Affairs Committee
Orlando Field Hearings
March 23, 1989

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE. I APPRECIATE THIS OPPORTUNITY TO SHARE WITH YOU SOME OF FLORIDA'S PERSPECTIVES REGARDING VETERANS ADMINISTRATION HEALTH CARE. THIS IS A PARTICULARLY APPROPRIATE TIME FOR THIS DISCUSSION, AND I HOPE MY DEPARTMENT WILL BE OF ASSISTANCE.

FIRST, LET ME EXPLAIN THAT MY INTENTION IS TO ADDRESS THE QUESTIONS UNDER CONSIDERATION IN A SLIGHTLY DIFFERENT ORDER FROM THAT PRESENTED IN CHAIRMAN CRANSTON'S LETTER OF INVITATION. I WILL FIRST DISCUSS ISSUES RELATED TO THE ADEQUACY OF FACILITIES AND RESOURCES ALLOCATED TO FLORIDA. THEN, I WILL ADDRESS THE ADEQUACY OF CARE HERE, AND LEAD INTO OUR FEARS ABOUT HOW A BUDGET SHORTFALL WILL AFFECT US. FINALLY, I WILL OFFER SOME THOUGHTS ABOUT HOW OUR PROBLEMS MIGHT BE ATTACKED.

FLORIDA, AS HAS BEEN UNDERSTOOD FOR SOME TIME, HAS FEWER VA HEALTH CARE RESOURCES THAN MOST OTHER AREAS OF THE NATION. THIS IS A VERY DISTURBING FACT - ONE MADE WORSE BY GENERALLY ACCEPTED VA PLANNING DATA WHICH WOULD OTHERWISE PREDICT EXTREMELY HIGH USAGE OF SUCH VALUABLE FEDERAL RESOURCES HERE.

A SHORTAGE OF VA FACILITIES, AND THEN, RESOURCES, IN FLORIDA MUST BE THOUGHT OF AS OUR CENTRAL PROBLEMS. THIS SPECIFIC ACKNOWLEDGMENT IS CRUCIAL TO AN ORIENTATION OF HOW MY STATE REGARDS THE OTHER ISSUES UNDER DELIBERATION TODAY.

FLORIDA HAS THE OLDEST MEDIAN AGE VETERAN POPULATION IN THE NATION. VA TECHNICAL REPORTS HAVE LONG IDENTIFIED THE RAPID INCREASE IN USAGE OF VA FACILITIES AS VETERANS AGE.

HOWEVER, WE HAVE BUT TWO-THIRDS OF THE AVERAGE NUMBER OF VA HOSPITAL BEDS AVAILABLE NATIONALLY PER 1,000 VETERANS. THE ADDITION OF 1,500 VA HOSPITAL BEDS WOULD BE REQUIRED TO GRANT FLORIDA VETERANS **AVERAGE ACCESS** TO VA INPATIENT CARE. WE ARE EXTREMELY FRUSTRATED THAT ONLY ONE-QUARTER OF THIS BADLY NEEDED TOTAL ARE NOW SLATED FOR CONSTRUCTION - AND, PERHAPS OF EQUAL SIGNIFICANCE, THAT THAT SINGLE FACILITY HAS BEEN DOWNSIZED AND DELAYED.

FLORIDA IS ALSO HOME TO THE LARGEST POPULATION OF TOTALLY DISABLED VETERANS IN THE COUNTRY - INCLUDING, MR. CHAIRMAN, THAT OF CALIFORNIA, WITH ITS TWICE-AS-LARGE VETERAN POPULATION. WE ALSO HAVE THE HIGHEST INCIDENCE OF DISABLED VETERANS OF ANY LARGE STATE. YET, CLEARLY DOCUMENTING THE SHORTAGE OF VA HEALTH CARE FACILITIES, FLORIDA ALSO IS THE LOCATION OF THE HIGHEST RATIO OF SERVICE-CONNECTED (VS. NONSERVICE-CONNECTED) OUTPATIENT TREATMENT IN THE UNITED STATES.

THE "FLIP SIDE OF THIS COIN" IS THAT WE ALSO "ENJOY" THE LOWEST LEVEL OF NONSERVICE, OR "DISCRETIONARY" CARE IN THE UNITED STATES. WHILE OTHER STATES FEAR PROBLEMS ASSOCIATED WITH SHORTAGES OF VA HEALTH CARE RESOURCES, WE HAVE ALREADY SUFFERED FROM THOSE SHORTAGES. WHEREAS THE SHRINKING "RESOURCE PIE" IS OF CONCERN TO ALL STATES, WE IN FLORIDA ALSO HAVE TO BE CONCERNED WITH OUR LESS-THAN-EQUITABLE SHARE OF THAT PIE.

KEEPING IN MIND THAT DISCRETIONARY CARE IS "MEANS TESTED", THIS GUARANTEES VETERANS DENIED VA CARE IN FLORIDA ARE OFTEN UNABLE TO AFFORD CARE ELSEWHERE.

GIVEN THE PRESENT-DAY AUTHORITY FOR THE VA TO PROVIDE DISCRETIONARY CARE, "WITHIN THE LIMITATIONS OF AVAILABLE FACILITIES AND RESOURCES, "THIS CREATES A BASIC QUESTION OF EQUITY. ALL AMERICANS PAY FOR THE OPERATION OF THE VETERANS ADMINISTRATION, BUT SOME CLEARLY BENEFIT MORE FROM THAT INVESTMENT THAN OTHERS.

IN RECENT YEARS THE MOST COMMON MEDICAL DIAGNOSIS IN VA MEDICAL DISTRICT 12 HAS BEEN THAT OF "PSYCHOSIS." WE FIND THIS PARTICULARLY TROUBLING, AS WE ARE THE **ONLY VA MEDICAL DISTRICT WITHOUT A LONG TERM VA PSYCHIATRIC FACILITY.** WE ARE FORCED TO WONDER HOW MANY FLORIDA VETERANS - VETS WITH CONDITIONS IDENTICAL TO THEIR PEERS ELSEWHERE WHO HAVE TYPICALLY BEEN INSTITUTIONALIZED IN LONG TERM VA PSYCHIATRIC CARE FACILITIES - HAVE BEEN FORCED TO GET LIMITED TREATMENT FROM STATE FACILITIES HERE IN FLORIDA.

HOW DO FLORIDA VETERANS CARED FOR OUTSIDE THE VA GET TREATMENT WHICH IS RESPONSIVE TO THEIR PROBLEMS? WE BELIEVE INVESTIGATION OF HOW MANY OTHERWISE ELIGIBLE VETERANS ARE NOW IN LOCAL PSYCHIATRIC PROGRAMS, FUNDED BY THE STATE AND ITS POLITICAL SUBDIVISIONS IN FLORIDA, WOULD BE ENLIGHTENING.

ONE FINAL NOTE IN THIS RESPECT. WE HAVE HEARD THE CLAIMS THAT OUR DESCRIPTIONS OF HOW SERIOUS OUR PROBLEMS ARE IN FLORIDA ARE OVERSTATED. INSTEAD, IT HAS BEEN POINTED OUT THAT OUR PRESENT FACILITIES DO NOT REMAIN FILLED - THAT BED OCCUPANCY DOES NOT REMAIN AT CAPACITY. THIS SEEMS TO ME TO COMPLETELY MISS THE POINT THAT THE VA REPRESENTS A "CLOSED SYSTEM." IT NEED NOT ACCEPT ANYONE WITHOUT ITS APPROVAL. THE VA ITSELF COINED THE TERMS OF "SUPPRESSED" AND

"CONSTRAINED DEMAND" FOR ITS HEALTH CARE SERVICES HERE. WE CAN ONLY HOPE IT IS FULLY UNDERSTOOD THAT THE DENIAL OF REQUESTS FOR ITS HEALTH CARE IN FLORIDA - AND THE RESULTANT FACT THAT OUR PRESENT BEDS ARE NOT FILLED TO CAPACITY - CANNOT BE USED TO JUSTIFY AN INEQUITABLE ALLOCATION OF RESOURCES.

WERE A MORE APPROPRIATE STANDARD SOUGHT, IT MIGHT BE THE TOTAL NUMBER OF COMPENSATION AND PENSION EXAMINATIONS RENDERED: IN VA MEDICAL DISTRICT #12 WE HAVE THE LARGEST NUMBER IN THE NATION. IF THAT FACT IS NOT COMPELLING, CONSIDER THE VA DATA ON HOW OFTEN IT DETERMINES ITS CARE IS REQUIRED, BUT THE REQUIRED MODE OF TREATMENT IS NOT AVAILABLE: AGAIN, MEDICAL DISTRICT #12 IDENTIFIES, ROUTINELY AND BY FAR, THE LARGEST NUMBER OF THOSE OCCASIONS IN OUR NATION. OVERALL, FLORIDA EXPERIENCES THE LARGEST NUMBER OF DENIED REQUESTS FOR VA CARE IN THE VA ENTIRE SYSTEM. I HOPE THIS PERSPECTIVE ENDS ANY THOUGHT THAT FLORIDA DOES NOT HAVE A SERIOUS PROBLEM IN THIS CONTEXT.

HAVING SAID ALL THIS, MY COMMENTS ON THE REMAINING QUESTIONS WILL BE MUCH BRIEFER. SUFFICE IT TO SAY, MY VIEW ON THE "ADEQUACY OF VA CARE" DEPENDS ON WHAT IS ACTUALLY BEING ASKED. IF ADEQUACY IS INTENDED TO MEAN DO WE HAVE ADEQUATE FACILITIES TO MEET OUR IMMEDIATE AND LONG TERM NEEDS, THE OBVIOUS ANSWER IS NO. IF, HOWEVER, ADEQUACY IS INTENDED TO INVITE AN EVALUATION OF THE QUALITY OF CARE OFFERED BY THE VA IN FLORIDA I WILL DEMUR. I AM NOT PREPARED TO DISCUSS THE QUALITY OF CARE AFFORDED, BUT AM CONCERNED THAT THE TREND WOULD APPEAR TO BE ADVERSE. ONCE WE GET CARE FOR OUR RESIDENTS, THEN WE CAN AFFORD TO CONERN OURSELVES AT GREATER LENGTH ABOUT QUALITY.

HOWEVER, THE COMMITTEE MAY WISH TO CONSIDER A REVIEW OF THE NUMBER OF TORT AND SUBSECTION 351, USC, CLAIMS WHICH HAVE RESULTED AS A PROPORTION OF ALL CARE RENDERED BY MEDICAL DISTRICTS. PERHAPS A REVIEW OF THIS TYPE WOULD SHED LIGHT ON THE QUALITY-OF-CARE ISSUE.

THE PROBABLE EFFECT OF A VA HEALTH CARE BUDGET SHORTFALL IS MANIFEST TO THOSE OF US WHO HAVE WORKED WITH FLORIDA'S VETERANS. FOR YEARS WE HAVE HEARD THAT WE NEEDED TO BE PATIENT AND OUR NEEDS WOULD BE MET. EACH OF THE LAST 4 ADMINISTRATORS HAS PROMISED A REVIEW OF OUR CRISIS SITUATION, TOGETHER WITH THE COMMITMENT TO MAKE APPROPRIATE ADJUSTMENTS. HOWEVER, THE FEDERAL FISCAL SCENE IS SUCH THAT OUR PROBLEMS REQUIRE: 1) EITHER A REALLOCATION OF EXISTING VA HEALTH CARE RESOURCES - FROM AREAS OF RELATIVELY LOW USAGE TO OUR AREA OF HIGH DEMAND, OR; 2) APPROPRIATION OF ADDITIONAL RESOURCES TO CONSTRUCT NEW FACILITIES TO ALLEVIATE THE STRESS WE NOW EXPERIENCE, OR; 3) SOME INNOVATIVE, UNCONVENTIONAL APPROACH.

I REGARD THE APPROPRIATION OF MAJOR NEW OR ADDITIONAL RESOURCES DURING THE SHORT TERM AS BEING HIGHLY UNLIKELY. FIRST, I THINK THE PRESSURE TO CONTROL THE BUDGET DEFICIT WILL PREVENT THIS FROM HAPPENING. SECONDLY, I SUSPECT FEARS ABOUT INCREASING THE NUMBER OF OPERATING FACILITIES WILL ALSO MIRROR CONCERNS ABOUT RAISING THE RECURRING BASE BUDGET OF THE VA. GIVEN THAT VA RESOURCES FOLLOW THE CONSTRUCTION OF ITS FACILITIES - NOT THE OPPOSITE - THE TACTIC OF AVOIDING SYSTEMIC EXPANSION AS PART OF A LONG TERM STRATEGY FOR CONTROLLING THE BUDGET SEEMS INEVITABLE.

EXPECTING A REALLOCATION OF VA FACILITIES AND RESOURCES IS ALMOST AS TROUBLING. THE VETERANS ADMINISTRATION HAS OPERATED FOR MANY YEARS WITHOUT STATUTORY GUIDANCE ON HOW TO ALLOCATE ITS FACILITIES. IN FACT, THAT PROCESS HAS LARGELY BEEN A POLITICAL ONE. TO EXPECT TO ADDRESS FLORIDA'S PROBLEMS IN THIS MANNER IS TO INVITE NOTHING LESS THAN A CHALLENGE OF A LIFETIME; CONFLICTS WITH OTHER MEMBERS WHO WOULD LOSE IN THAT "REDISTRIBUTION OF THE WEALTH" WOULD QUICKLY TAKE SHAPE AS MAJOR TURF BATTLES. NONETHELESS, UNTIL FIRM CRITERIA FOR CONSTRUCTION OF FACILITIES ARE ESTABLISHED, SUCH BATTLES ARE PREDICTABLE.

THE LOSERS IN TODAY'S ALLOCATION OF FEDERAL RESOURCES WILL, EVENTUALLY, HAVE THEIR DAY. BESIDES THIS, I BELIEVE EVERYONE HAS A VESTED INTEREST IN THE VA'S RESPONSIBLITY FOR A CENTRALIZED FEDERAL SYSTEM BASED ON EQUITABLE CONSIDERATIONS. VETERANS - WHO HAVE **EARNED ENTITLEMENTS** - DESERVE NOTHING LESS.

THE FINAL POSSIBILITY IS THAT OF SOME INNOVATIVE, TO DATE UNCONVENTIONAL APPROACH TO GUARANTEEING EQUALITY OF ACCESS TO VA HEALTH CARE. ON THE SURFACE THIS SEEMS TO HOLD THE GREATEST PROMISE FOR FLORIDA. HOWEVER, THIS PROSPECT ALSO AROUSES THE FEARS OF SOME VETERANS ORGANIZATIONS WHO FEAR THE OBVIOUS MEANS AVAILABLE.

PERHAPS THE MOST OBVIOUS POSSIBILITY IS THAT OF A GREATER RELIANCE OF SOME TYPE OF FEE BASIS SYSTEM WHICH YIELDS TO FLORIDA VETERANS INCREASED TREATMENT WITHOUT ADDITIONAL CONSTRUCTION OF FACILITIES. THIS APPROACH MIGHT BE THOUGHT OF AS "BUILDING EQUITY INTO THE SYSTEM, RATHER THAN BUILDING ADDITIONAL FACILITIES". CONCEPTUALLY THIS SOUNDS ATTRACTIVE

BUT, HOW WOULD IT BE ADMINISTERED AND WHO COULD RECEIVE TREATMENT?

FURTHER, WHILE WE MAY SPECULATE THAT THE HEALTH CARE PROVIDERS OF FLORIDA WOULD EMBRACE THIS PROSPECT WITH OPEN ARMS, WE KNOW IT WOULD ALSO BE ADAMANTLY OPPOSED BY VETERANS ORGANIZATIONS. VETERANS GROUPS HAVE LONG BEEN SCHOOLED TO WATCH FOR A DEVELOPMENT OF JUST THIS SORT AS THE FIRST SIGN THAT THE VA HEALTH CARE SYSTEM WAS BEING ELIMINATED. AT A TIME WHEN THE SYSTEM IS ALREADY VIEWED AS UNDERFUNDED - UNDER FRONTAL ASSAULT BY OTHERS - ITS CLEARLY A VERY SENSITIVE OCCASION FOR EVEN THINKING ABOUT CHARTING NEW COURSES FOR THE VA. **SOME ASSURANCE MUST BE PROVIDED TO VETERANS BY THE FEDERAL GOVERNMENT THAT ANY CONSIDERATION OF AN ENLARGED FEE BASIS SYSTEM WOULD BE A "STOP-GAP" MEASURE, AND, IN NO WAY WOULD JEOPARDIZE THE CREATIION OF NEEDED FACILITIES AND THE PROVISION OF NEEDED RESOURCES.**

IN FACT, THE ONLY CERTAINTY IS THAT THERE ARE NO EASY ANSWERS FOR FLORIDA AND ITS VETERANS. HOWEVER, IT SHOULD BE NOTED THAT FLORIDA NEITHER CREATED NOR, IN ANY WAY, CONTRIBUTED TO THE PERPETUATION OF THE PROBLEMS IT NOW EXPERIENCES WITH VETERANS ADMINISTRATION PROGRAMS. IT IS, HOWEVER, WILLING TO ASSIST IN THEIR RESOLUTION IN ANY REASONABLE WAY.

THANK YOU FOR YOUR ATTENTION AND CONCERN THIS MORNING.

STATEMENT OF
JERRY L. DUGAN, NATIONAL DIRECTOR
OF THE
CENTRAL FLORIDA CHAPTER
PARALYZED VETERANS OF AMERICA
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
THE STATUS OF VETERANS' HEALTH CARE
IN THE STATE OF FLORIDA
MARCH 23, 1989

Mr. Chairman , on behalf of the members of Paralyzed Veterans of America and all veterans residing in the State of Florida I greatly appreciate this opportunity to present views and concerns regarding the state of programs and services provided by the Department of Veterans Affairs in the State of Florida.

I am Jerry L. Dugan, National Director of the Central Florida Chapter of Paralyzed Veterans of America the preponderance of whose members reside in the Orlando area and the central part of the State. PVA also has two other chapters located in the State; the Florida Chapter in the Miami - Ft. Lauderdale area and the Florida Gulf Coast Chapter in the Tampa area. PVA also has a staff of service officers sited throughout the State who assist both PVA members and all veterans.

M. Chairman, all of PVA's member have experienced catastrophic spinal cord injury or disease and because of the nature of these disabilities PVA's members are very reliant upon the VA's health care system and are, therefore, very conscious of the pressures and problems currently besetting the system. As the Committee is aware the DVA operates two specialized Spinal Cord Injury Centers in the State; one in Miami, the other in Tampa. While PVA members rely a great deal on these two SCI centers for specialized medical care we also utilize other DVA facilities located throughout the State. Additionally, PVA's service personnel deal with all the medical facilities in Florida and are in almost daily contact with the problems veterans are encounter.

The situation in the State of Florida appears to be the result of two very distinct factors. The first is national situation with funding for veterans' health care and services being inadequate. PVA has witnessed the continual underfunding of the Veterans Administration for a number of years. It is for this reason that PVA, in conjunction with Disabled American Veterans, the Veterans of Foreign Wars and Amvets, has developed an "Independent Budget" for the VA which was submitted to this Committee by our National President and our National Office. I am confident that the Congress, as they have in past years, will view this document as an honest assessment of the true needs of this Nation's veterans and will work to improved the funding levels recently contained in the Administration's budget proposal.

The second factor is a unique Florida problem - the astronomical growth in our veteran population. While we are all proud of the many attractions of our State these very conditions are contributing to the crisis we are facing.

For years veterans have been moving to the State in record numbers either permanently or on a seasonal basis. As the veteran population has grown the system of medical care and services for veterans has not been able to keep pace. When these dual factors, increased demand and reduced resources, are present there can be only one possible outcome, deteriorating services and availability of care.

PVA's service officers report problems occurring at facilities throughout the State. Outpatient treatment at Miami, Key West, Oakland Park, Riviera Beach and Orlando has been severely restricted. At all of these facilities treatment for non-service connected veterans is only available to obviate the need for hospitalization. For those veterans who are in either Category "B" or "C" and are not in need of emergency care, outpatient care is totally unavailable.

In the case of the Outpatient Clinic here in Orlando problems abound. First, the physical facility is wholly inadequate for the number of veterans requiring care. Extended waiting times have become the norm. Examinations for Compensation and Pension claims are continually delayed due to the shortage of both staff and facilities. Over the counter medications and supplies have been discontinued for both service connected and non-service connected veterans. This is particularly devastating for PVA's members who require such supplies on a daily basis in order to maintain their well-being.

At the Bay Pines Clinic there are extensive waiting times for the hypertension and renal clinics. It has been reported to PVA that the facility has a $9 million shortfall for utilities, laboratory chemicals and prosthetics. The pharmacy is facing a shortfall of approximately $2 million.

Presently the facility is still providing over the counter medications and supplies but without additional resources their ability to operate during the fourth quarter is in doubt.

The Tampa hospital is currently operating all its clinics but has been forced to close 36 surgical beds due to staff shortages. The inability of DVA facilities to be competitive in the recruitment of needed medical care personnel, particularly nurses, has reached crisis proportions. The Spinal Cord Injury Center at Tampa is operating at its capacity even though the facility is short ten nurses. This can only result in potential problems in quality of care. The hospital is currently operating a deficit in the areas of pharmacy and prosthetics.

Mr. Chairman, the situation at the Tampa SCI unit is at a critical juncture. PVA has long advocated for an additional SCI unit to be constructed at Gainsville and for the Tampa unit to be expanded to accommodate the ever increasing demand placed upon it. PVA recently conducted a site visit at the Tampa facility and found the unit to be in need of immediate assistance. Beyond the staff shortage, the physical facility was found to be inadequate for patient demand and, yet, other SCI facilities are referring patients to this unit.

On February 28 PVA's National President, Jack Michaels, recommended an interim solution to this Committee and the House Committee on Veterans' Affairs during our annual testimony to the space problems presently besetting the Tampa SCI unit. He stated:

> "...for example, a recent visit to the Tampa SCI Center resulted in exemplifying the problems that have occurred because of a crucial lack of clinical space. Clearly, an additional building is required. If a permanent unit is approved in the FY'91 budget, the earliest occupancy would be in FY'95 or '96. It is just too long to wait when a simple low-cost remedy is at hand.
>
> Therefore, we are recommending that them VA purchase a modular building with approximately 10,000 sq. ft. to house 30-40 people engaged in a variety of tasks that are essential to the efficient operation of the center.
>
> We estimate the construction cost of this interim solution to be under $500,000, including all hookups and utilities. This seems to us to be an innovative way for the VA to solve this problem immediately."

Mr. Chairman, we believe this is a very appropriate short term fix but the real need for the spinal cord injured veterans of this State is the addition of a Spinal Cord Injury Center at the Gainsville VAMC. This project has been included in various Congressional construction proposals over the past several years and advanced planning funds have already been expended for the project, however, the VA in December announced their decision to eliminate this project and expanded the proposed Tampa addition. This approach will only delay the availability of necessary facilities and restrict the geographic distribution of available health care access for spinal cord injured veterans.

The Miami VAMC and its Spinal Cord Injury Center are also experiencing staff shortages, however, due to limited demand at this time this is not having an adverse effect on patient care. It does, however, point out the absence of coordination within the State among VA facilities. Tampa SCI is overburdened with interfacility transfers and local patients while the Miami unit has available beds. I must note, however, that additional patients can exacerbate the Miami situation since the unit has no available intensive care or respiratory beds.

Miami is experiencing problems similar to other facilities in the State. Prosthetic availability is extremely limited due to budgetary curtailment with only the most vital materials being provided. There is currently no provision of over the counter medications or supplies. And, the waiting list for access to nursing home care is prohibitively long.

Waiting times should come as no surprise to veterans in this area though since this is a Statewide problem. At Gainsville the treatment of PTSD [Post-Traumatic Stress Disorder] is currently restricted due to the shortage of available facilities. The podiatry clinic is open only one day a week and 50 - 70 patient are seen each day; this calls into question the comprehensive nature of each exam or treatment. Gainsville has experienced a reduction in the number of available medical care beds and a cut of 30 nursing beds. All this at a time when the demands are growing.

Mr. Chairman, I thank you on behalf of the veterans of Florida for conducting this hearing. As I have attempted to point out there are two major forces at work affecting the quality and quantity of health care available to veterans here. One, the growing veteran population, we have no control over. The second, inadequate resources, you, hopefully, can address.

Thank you and I will answer any questions that I can.

THE UNITED STATES SENATE

COMMITTEE ON VETERANS AFFAIRS HEARING

ORLANDO, FLORIDA

REMARKS ON BEHALF OF THE AMERICAN LEGION

DEPARTMENT OF FLORIDA

by

Frank Reese, Department Commander

Robert J. Jackson, Legislative Chairman

MARCH 23, 1989

COMMANDER REESE'S REMARKS

Mr. Chairman:

On behalf of the over 100,000 members of The Florida Department of The American Legion we welcome this opportunity to present to you and members of the Committee, the views of The Florida American Legion on the necessity of increased funding for the Veterans Administration Medical Centers throughout the Sunshine State.

I am asking my Legislative Chairman, Mr. Bob Jackson, to present to you The American Legion's position. I will relinquish my time at this point to Mr. Bob Jackson, our Legislative Chairman.

REMARKS BY ROBERT J. JACKSON, LEGISLATIVE CHAIRMAN FLORIDA DEPARTMENT OF THE AMERICAN LEGION

Senator Graham and Members of this Distinguished Committee:

The Florida Department of The American Legion knows far too well the extreme problems that we are faced with in the delivery of health care to the veterans of the state of Florida.

We are very pleased to make this presentation today. However, we were disappointed at the number of members of the Committee that could see fit to come to the Sunshine State for this hearing. We sincerely believe they are the individuals that we must make aware of the severity of this crisis. We know Senator Graham is very aware of these problems. However, we must convince his colleagues in the Senate and the House of the continuing problems we face here due to the ever-increasing population of veterans in the Sunshine State.

Everyone certainly agrees that the delivery of health care to veterans of the United States is a Federal problem. However, with our representative form of government, we feel that although our Congressional Delegation is aware of the problem, your colleagues, representing their own states, are either unaware or unwilling to give up any of their VA funding within their states. We need assistance in picking up the deficit created when their constituents move to the Sunshine State.

One of the main issues that we must focus on today is the lack of response time by the Veterans Administration and the Federal Government in providing us parity in the delivery of health care to the veterans who reside in this state.

As we sit here today on March 23rd, we are working on the fiscal budget for 1990 to 1991.

The Veterans Administration budget for that fiscal year will be constructed based on experiences of veterans who have visited medical facilities for discretionary, non-discretionary and out-patient care in the calendar year 1988. That immediately puts the Veterans Administration budget two years behind the real-time delivery of necessary funds for health care.

We all realize that 3,000 to 5,000 veterans permanently move to Florida each month. Using an average of 4,000 veterans per month times the 24 months of lapsed time until this budget will go into effect, figures used in compiling the proposed budget will need to service 96,000 more veterans in 1990 than was budgeted. At this pace, we will never be able to properly and adequately care for the veterans who are in need.

I would also remind this distinguished committee that The American Legion did a survey two years ago as to the type of veteran that is using the VA system. We found that less than 5% of the veterans who use the Veterans Administration medical system are veterans who have financial resources to seek medical assistance through the private sector. That means, simply, that 95% of the veterans who currently use the Veterans Administration are citizens that have nowhere else to go.

Two years ago the Administrator of the Veterans Administration was given authority to shift a small amount of funds between medical districts on an annual basis, based on need. The Florida Department of The American Legion asks that consideration be given for the new Secretary of the Department of Veterans Affairs to be allowed to shift additional funds to those medical districts that are receiving increases in veteran population on a continual basis.

This action would be of immediate assistance in meeting short-falls in the delivery of health care to our veterans. A perfect example is in the current fiscal year's funding. Based on information obtained by The American Legion, it appears that the Veterans Administration will experience a 500 million to 1.2 billion dollar shortfall of the necessary funds to effectively provide care to this nation's veterans. This means further shortfalls, the curtailing of the delivery of services, and a further screening of veterans based on their needs.

We ask that this committee also use all the influence possible through OMB for a fiscal year 1989 supplemental appropriation of $314 million and an appropriation for 1,539 full-time employees so that the Veterans Administration may restore "current services" to their 1988 levels.

We ask that the Congress move quickly to approve this additional funding. The American Legion is currently conducting a survey of all hospital directors throughout the nation to get real-time shortfalls that they are experiencing due to budget cuts. This survey is approximately 90% complete, and will be released soon. I ask that the Congressional Delegation pay close attention to the results of this survey because it will be from the front-line troops who are facing these severe budget cuts.

Our preliminary statistics and results tell us that we will be quite shocked at the drastic effects the budget cuts are having in the medical care of the veterans of this nation.

We feel the issue of capital expenditures by the Veterans Administration is also an area that must be addressed, particularly in the Sun Belt States.

As we sit here today there are no long-term psychiatric beds available for the of veterans in the state of Florida. With the issue of post-traumatic stress and other mental disorders, the outlook for veterans is bleak. There is no Federal facility in the state of Florida to give these veterans long term care. We might point out that the need for these psychiatric beds was established and recognized by the Veterans Administration Central office in fiscal year 1975, 14 years ago. However, the planned 290-bed psychiatric facility is placed continually on the back burner and not funded. We would ask that this become a high priority. Of the 27 medical districts, we are the only one that does not have longterm psychiatric facilities.

Also, in the area of capital expenditures, the Veterans Administration must go forward with the plans to adequately fund the two additional hospitals that have been planned through the 30 year study, and the Bed Site Study that has been developed by the 12th Medical District.

It is imperative that this valuable document be followed to adequately meet the needs of the veterans.

It is also necessary for the spinal cord injury (SCI) facilities to be included in the Tampa Clinic. We are in severe need of facilities to adequately care for those veterans who have had spinal cord injuries. It is a very unique medical need that takes specialized facilities and personnel with specialized training. We ask that this committee pay special attention to this area of responsibility to insure that this project goes forward on a timely basis.

We would like to bring to this committee's attention an issue we feel is a travesty of justice in a theoretical setting. I am referring to the means test and the co-payment billing collection system. The means test and the third party reimbursements have been in place through the Veterans Administration for approximately two years.

As the system currently operates, the Veterans Administration delivers health care to a veteran who, in some cases, does have adequate insurance and that insurance company is billed for the veteran's care. When the insurance company reimburses the government for that care, it is not credited to the Veterans Administration. It is sent to the Treasury as general revenues.

We do not feel this is a fair and adequate system when, in fact, the Veterans Administration should be directly reimbursed, since it is the agency that funded the original care. We feel this has a negative effect on the delivery of health care to the veterans. As an example, recently released Veterans Administration figures of recoveries showed that the total recovery in 1987 was $6.6 million. In 1988 it was $11.8 million.

Compared to the overall Veterans Administration budget these are not large sums of money, but they certainly could have a positive effect on the delivery of health care. As you approach this 1990 budget this will be an issue that must be discussed, since this process was part of the 1986 Reconsolidation Act of Congress that has a life of three years. As you and your colleagues deliberate this issue in the 1990 budget, we ask that serious consideration be given to those funds being returned to the Veterans Administration annually, rather than going into the Treasury as general revenue.

In Florida, with the increased population of veterans, accessibility to facilities of the Veterans Administration has reached the crisis point.

Of the 27 medical districts, Medical District 12 has the lowest ration of Veterans Administration employees and facility access per thousand veterans. After working very closely with the employees in the 12th Medical District, we want to commend these individuals for the dedication they have to America's veterans and to the Veterans Administration. These individuals are unsung heroes who are continually faced with the crisis of diminishing resources, but they continue to deliver high quality health care in a very professional manner.

Based on 1987 figures the 12th Medical District had by far the highest percentage of non-discretionary visits by veterans for service-connected medical problems of any medical district. Sixty-three percent of these veterans were service-connected; whereas, the national average is 45.60 %. Across the board, the 12th Medical District veterans have less accessibility to VA medical facilities than any other group of veterans in any other district.

We would like to refer you to the Florida Commission On Veteran's Affairs 1988 Annual Report. This report deals with the inadequacy of the Veterans Administration delivery system using comparative analysis. It is our understanding that copies of this document have been provided to the Congressional Delegation. Many of the aforementioned inadequacies are illustrated in this document.

Through our network of over 100,000 members and 336 American Legion Posts, we continually hear "war stories" of individual experiences at the Veterans Administration facilities concerning claims or medical care. However, we feel with the limited time we have today, it is more important to present our position on the overall problems in the big-picture concept. We feel that the following remedies are possible avenues to the elimination of these inadequacies. The veterans of this country who have offered their lives to protect the freedoms we enjoy certainly deserve no less.

Individual members of both the House and Senate must be willing to accept the responsibility of increasing the Veterans Administration Budget over other social programs to adequately care for those individuals who have suffered disability in service to this Country.

In the political arena everyone want to be a hero. It may well be time to "bite the bullet". Individual members of Congress must proceed more aggressively to adequately fund the Veterans Administration budget in order to provide necessary services to this nations veterans.

The Veterans Administration must develope an internal financial structure within the budget to allow the shifting of funds within a given fiscal year to follow the change in population between the medical districts.

As we approach the 1990's and the ever increasing age of the World War II veteran, the need for special care, particularly in the area of nursing homes, and domiciliary and geriatric care, will be ever increasing.

Also, the mean age of the Korean and Vietnam veteran is certainly reaching middle age. The Veterans Administration must anticipate and prepare for these additional generations of veterans who will be facing those medical problems we all face with increasing age, and do so in an adequate manner.

This issues of care for veterans of Vietnam who are suffering from post-traumatic stress disorder and the development of adequate programs for victims of Agent Orange must be realistically addressed by the Veterans Administration.

I would remind this Committee of The American Legion/Columbia University's studies on the effects of Agent Orange. This documented, scientific study gives new insight into the effect of Agent Orange on veterans. We hope this Committee and the Veterans Administration will use this valuable scientific information to actively develop an adequate treatment program.

Some seven years ago the Veterans Administration medical districts developed a strategic plan, along with a 30-year Bed Site study. All these studies were done professionally and are valid from a scientific and statistical stand point. These studies are not a "Christmas wish list" - they are based on fact and must be used when considering funding for Veterans Administration facilities.

We in Florida are very fortunate in that the 12th Medical District has a very strong network among the veterans organizations and the Congressional Delegation. The 12th Medical District is interacting and networking to insure that the available federal dollars are maximized. Although we have faced disappointment after disappointment from the budgeting process, we feel we know what the needs are and continue to strive to reach them.

Every day of procrastination on the part of the Congress by improperly budgeting the Veterans Administration is costing veterans their lives. The lack of adequate facilities can only be detrimental to the veterans welfare. Although I am sure it is not the case, there seems to be an apparent lack of aggressive concern by many members of Congress for the fact that veterans are aging, as though if we procrastinate long enough, the problem will die away. This is a attitude that can do great harm to the morale of this entire country. It might possibly have severe effects on the entire national defense of this country. If we were to have a national crisis, the knowledge that their Country did not care for those veterans of past wars might instill in our young people an unwillingness to serve their Country. This is a consideration that cannot be discounted.

We call upon this committee to insure that those medical districts that are having the greatest shift of veteran population receive the attention that they deserve. The capital expenditures must be made and the funding be put in place to provide the medical care equal to that which veterans in other states have received on a consistent and continual basis. To do less would be to neglect the duties of the office to which you were elected.

The Office of Management and Budget is continually wreaking havoc with the Veterans Administration budget. It is our opinion that they simply do not understand the problems that face us.

Our statistics show that, by-and-large, the veterans using the Veterans Administration facilities have nowhere else to go to seek the help they need.

The problem is one of a veteran's "expectation", and the Veterans Administration's reality. Webster's dictionary defines expectation as "the state of being expected." Unfortunately, many of the Veterans find that their expectations in their approach to the veterans Administration are turned to disappointment when reality strikes and there is not adequate funding to provide the medical care and pharmaceutical needs to treat their ailments and prolong their lives.

Through your active and aggressive participation on this Distinguished Senate Committee, we sincerely hope that the veterans of the state of Florida will begin to see a significant shift in Veterans Administration funding to the 12th Medical District so that we may adequately care for every aging veteran who has served his country.

We thank you for this opportunity to present our views to this committee. We will be happy to answer any questions you may have at this time.

STATEMENT OF

EDWIN H. SHUMAN
LEGISLATIVE OFFICER
DEPARTMENT OF FLORIDA
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE

ORLANDO, FLORIDA MARCH 23, 1989

MR. CHAIRMAN:

My name is Ed Shuman, and I am proud to represent the more than 100,000 men and women of the Veterans of Foreign Wars, Department of Florida, and its ladies Auxilary.

The Department of Veterans Affairs ability to properly fulfill its stated mission: "to ensure quality medical care is provided on a timely basis to eligible veterans" is now in very serious jeopardy. The DVA health-care budget is strained to the absolute limit and it is now evident that DVA is facing its most severe financial crisis in many years.

At the very heart of the problem--not enough money. Even though Federal funding for veteran's health care has nearly doubled since 1980 to $10.4 billion in FY 1989, after inflation is taken into account, there has been practically no gain whatsoever. During this period, the Department of Veterans Affairs health-care system has been treating more patients than ever before.

In fact, while other federal budgets are increased, DVA budgets are falling behind inflation. Since 1985, Medicaid spending has grown by 55 percent and Medicare spending is up to 32 percent. Spending for veteran's health care, on the other hand, has increased by only 17 percent over the same period. Since 1980, DVA patient workloads have increased substantially--the number of hospital patients is up seven percent, outpatient visits have increased by 29 percent, veterans receiving DVA paid-nursing home care is up 63 percent; however, the DVA's medical budget has been increased by only $400 million in real dollars during this period.

The Reagan Administration budget for the DVA is FY 1990 would have cut nearly 9,000 health-care employees, reduced medical facility construction and denied medical care to thousands of veterans. The DVA health-care system has already begun terminating health-care programs, taking hospital beds out of service (in addition to the thousands of surreptitiously closed "phantom beds") and to deny health care to category "B" and "C" veterans at virtually every DVA hospital in the country.

Substantiating the VFW's analysis of the severity of the problems facing the DVA health-care system, Veterans' Affairs Committee and DVA officials themselves are now predicting that the DVA medical funding shortfall will reach $1 billion to $1.5 billion for FY 1990 unless Congress provides supplemental money.

This rapidly escalating health-care tragedy for veterans is now being felt at virtually each and every one of the DVA 172 hospitals. Throughout the system, services are being terminated, the replacement of vital equipment is inadequate and in some cases almost nonexistent; critically needed construction, renovation and repair are being being curtailed; medical supplies are in increasingly short supply and more and more veterans are being turned away from needed medical treatment.

Mr. Chairman, I would also like to comment on a phenomenon which is a growing concern to the VFW. It is becoming more and more apparent that DVA is being challenged to do more work with fewer resources. The VFW does not profess to have all the answers, but we do know that if the Department of Veterans Affairs is going to be expected in the future to shoulder more of the load, then it only stands to reason everyone is going to have to work together to provide the necessary resources. For example: DVA has treated approximately six percent of this nation's AIDS cases and it is estimated that DVA is now treating about nine to ten percent of all new AIDS cases. Granted, the DVA budget for FY '90 calls for an increase in funding for AIDS treatment and research, but it will be provided at the expense of other vital DVA health-care programs. Each year, the number of AIDS cases discovered by the Department of Veterans Affairs has risen steadily--from 211 in 1983 to about 2,200 last year. In those years, DVA has been forced to take an already inadequate health-care budget and commit funds to expensive AIDS treatment. Not only is DVA a leader in AIDS research and treatment, it is also heavily committed to alcoholism and drug treatment, Alzheimer's research and in addressing the troubling issue of the homelessness among the veteran population. These are not only veterans' concerns--they are national concerns as well.

It seems to the VFW that when a national crisis such as the AIDS epidemic becomes a national priority, the Administration is willing to adequately fund treatment and research. However, the Administration does not seem to realize DVA's involvement and how much of the load the Department is carrying. It is time, Mr. Chairman, to recognize DVA's successes. We must properly fund the Department of Veterans Affairs land acknowledge that this Department is not only treating veterans, but contributing to the well-being of our entire nation.

Health care for veterans in the State of Florida is at a critical state. In this era of expanding veterans population, we need more hospitals and outpatient clinics. We do not need cutbacks in those that are already here. Additionally, we need to have medical care availability to be the same in all VA facilities. The non-service connected veteran in Florida should get the same care as the non-service connected veteran anyplace else in the country. There should be no difference in availability of treatment to eligible veterans. There are inequities even within the State of Florida as far as care provided to eligible veterans.

The VA Medical Center in Gainesville, Florida has closed a total of fifty beds and is planning on closing twenty more. The reason for this closure is not lack of veterans needing care, it is lack of adequate budgeting to staff the facility to enable those beds to remain in use. In our judgment, this shows a completely convoluted concern for veterans. We hear constantly from our National leaders that veterans' care is a priority. This appears to be lip service. Especially so, in light of instances such as we just sighted at Gainesville.

A classic example of unfair distribution of hospital beds is the comparison between Florida and Massachusetts. Florida ranks 42nd amongst the states with VA hospital beds, with the rate of 1.9 beds per thousand veterans. Massachusetts has about half as many veterans as Florida, but more VA beds. This gives the veteran in Massachusetts double the opportunity for treatment. For example: Florida had one veteran who required an eye operation that was non-service connected. The facility at VAMC Bay Pines was unable to do the surgery because it was non-service connected. The veteran flew to Massachusetts and was operated on by a VA Medical Facility there. He was able to afford the flight to Massachusetts because he was a retiree from an airline and was able to travel for free on that airline. He was also fortunate in that he had relatives in the area that he could stay with at no cost.

We have queried people working at the various VA medical facilities regarding their most urgent concerns in regard to the health care problem. They were in agreement that more treatment should be available to veterans--not less. A major concern is the category "A" veterans. They should be able to get treatment for all medical conditions. A military retiree, for example, cannot get treatment at a VA facility for a non-service connected condition, unless he is over 50% service connected disabled. The consensus is that veterans in Florida are hurting for treatment for non-service connected conditions because of low incomes. We have a great many people on fixed incomes as well as a great many low paying jobs. These people need the care the most and are least able to afford it. They often go without treatment because of lack of money to pay for private treatment. It makes more sense to us to provide NSC outpatient care to these type of individuals to obviate the need for hospitalization. It seems to us that it would be more cost effective to provide relatively low cost outpatient care to preclude the need for expensive inpatient care because of lack of proper medical attention. We think the VA should practice preventative medicine as opposed to crisis management medicine.

Another major concern is the lack of personnel to adequately staff facilities. The facilities desperately need more doctors, nurses, and administrative personnel to timely process the attendant paperwork. The veterans are here to fill the hospitals and outpatient clinics that are currently open. They are also here in sufficient number to fill those facilities proposed, but not yet built. Median age for veterans in Florida is 57 years old. Florida has the oldest veterans population in the nation. We also have the most severely disabled veterans in the nation according to VA statistics. Those statistics show that over 63% of all VA outpatient care in Florida was for service connected conditions , or conditions directly related to military service. The national average in this regard is 46%. That is a wide disparity.

Not only do we have a large permanent veterans population, we also have a large "snowbird" veteran population. Many veterans utilize the pleasant winter months in Florida, and at the same time utilize health care in Florida's VA medical facilities. This detracts from the availability of health care to our permanent Florida residents. We are in no way advocating that we provide less care to the transient population, we are advocating that we get more monies available to us to adequately care for the permanent and transient population. The

House of Representatives recently conducted a study that shows by the VA's on account that it would take an additional $45 million dollars, and 1,600 personnel to bring the VA health care employment level to equal staffing levels maintained by similar type facilities in their communities. If this additional funding were to take place, it would only accommodate current work levels. It would not address the total needs of the current, or future, veterans population in Florida. More concern needs to be shown for long term health care. Our aging veteran population is not being adequately cared for now. This will worsen in the immediate and long term future unless steps are taken immediately to alleviate the situation.

The Veterans of Foreign Wars in the State of Florida urge that the following actions be taken: (1) Senator Graham, you should introduce legislation that would return third party payments, and other funds received by the VA, back to the facility that provides the service. Payments currently go to a treasurer general fund and are not available to the specific facility that provided the service. This is grossly inequitable in Florida. We cannot strongly enough urge that action be taken to correct this inequity. (2) You should work to expedite the building of the Palm Beach Medical Center. You should also urge expeditious planning, and funding, for the other facilities that are contemplated in Florida. (3) We request you introduce legislation that will send the dollars to where the work is being accomplished. For example: Currently Florida facilities are sending prescriptions to the northern regions of the country to patients who winter in Florida. For those veterans with permanent residences in other states, that winter in Florida, or other sunbelt areas, portions of those budgets should be allocated to the areas where these veterans utilize facilities. (4) We urge you to work for federal funding to be available for state domiciliary and nursing home construction and operation. (5) We most strenuously urge you to work to increase the VA health care budget so that Florida's VA health care facilities will have adequate funding to accomplish their mission. That currently is not the case.

In summary, we stress the need for more adequate staffing, to insure that patients needs can be care for properly. We urge that more funding be made available so that hospital beds are no longer closed in Florida due to budgetary constraints. We urge that Florida receive its fair share of monies to provide facilities for the 1.5 million veterans who permanently reside and the many who are temporary residents. This will require an even closer look at distribution of VA monies to insure that more money is coming to the Florida facilities. We strongly recommend the VA change its system to issue medication to all category "A" veterans. This will, in many cases, obviate the need for hospitalization later. We recommend that VA care availability be the same in all VA facilities. Senator, we need your help, and the help of the entire Florida Congressional Delegation, to correct the deficiencies in the Florida VA health care scene. We should remember the motto of the Veterans Administration, quoted from President Abraham Lincoln, "to care for him who has borne the battle, and for his widow and his orphan." President Bush also eloquently stated the other day, "We must care for those who have served their country." Thank you for allowing the Veterans of Foreign Wars to appear before you and give testimony on these very serious concerns.

SENATE VETERAN'S AFFAIRS COMMITTEE

Remarks by

DEBORAH L. SHANNON, M.S.W.

Senator Graham and Members of this Distinguished Committee:

I am very honored that I was asked to make this presentation today as a representative of hospital social workers in the private sector. I am proud to represent South Seminole Community Hospital, a small acute care facility located in Longwood, Florida. Many of our staff members and physicians are also concerned about the issue of health care for the veteran. My presentation will not contain numerous statistics, but will basically deal with human issues that a private sector hospital encounters as it relates to the veteran. These issues relate mostly to your first and fourth areas of investigation dealing with availability and future needs. Also, most of the discussion deals with the veteran that has no third party payment source and seeks admissions to the VA system. We have had limited success and are greatly concerned about the future need of the Florida veteran.

Sometimes veterans experience emergency situations that result in acute care hospitalization at the nearest private sector facility. The veteran is usually asked at that time if he desires transfer to the nearest VA facility. The veteran who is normally treated at the VA hospitals and/ or is 100% service connected usually request transfer. The veteran who has no third party payment or might have some insurance with inadequate coverage also will usually request transfer. Often such a veteran has never accessed the VA system, or might have a non-service connected disability. Seldom does a veteran with group insurance coverage request transfer. Once the request for transfer has been expressed, a hospital representative will contact Fee Bases in St. Petersburg to initiate a check regarding the veterans eligibility in the VA system. A social worker will also automatically call the proper VA facility in the veterans catchment area to request transfer if it is known that the veteran is non-service connected disabled. It has been a fairly standard belief among private sector hospitals in the Central Florida area that this is as far as the request will go for most veterans. Availability to a VA hospital for the veteran who is non-service connected, who has never accessed the VA system, or whose primary admission diagnosis is not related to the service connected disability,is extremely difficult to accomplish in the State of Florida.

I again stress that the veterans who are often requesting transfer from the private sector acute care facility into the VA system are those veterans who do not have third party payment source, have probably been employed; and have found themselves in need of an emergency admission to the nearest local hospital in their community.

It was through the desperation of one such veteran and his ordeal to achieve access to a VA hospital that I am making this presentation today. Perhaps the best way to succinctly explain the frustration such veterans often experience is to retell a condensed version of this particular story.

A veteran from North Florida was in the Orlando area working on a construction job when he became very ill and presented himself to South Seminole Community Hospital's emergency room. This veteran, his wife, and his sister were all concerned that he be transferred as quickly as possible as he had no third party payment source. This veteran had also never been ill and had never had reason to access the VA system.

The veteran's sister was from a Northern state and had previously worked for the VA in that state before her retirement. I reassured her that the request for transfer had been made. I further explained it was common experience that such a transfer probably would never transpire before the patient was ready for discharge from our hospital. The sister was appalled and uttered the standard statement heard in almost all similar situations:

> Is it not the function of the VA, to provide free medical care to all veterans in need of such care who have served their country?

It is hard to explain the Florida VA system to veterans and family members that are not actively involved in a veterans service organization or who are accustomed to using VA facilities outside the state of Florida. It is hard for them to understand that this system is over burdened and probably has not received its fair share of federal allocation based on the number of veterans in our state. Furthermore, it is extremely difficult to transfer a stroke patient or spinal cord injury patient from a acute care private sector hospital into a VA rehabilitation program. It is hard for veterans and families in crisis situations to understand this rationale.

However, this veteran's sister was a very determined person. After a few intense, frustrating days she called the VA in Washington D.C. who apparently put her in touch with Senator Graham's office in Tallahassee. She also asked me to call on the family's behalf as the family feared they would loose their life savings.

Senator Graham's office staff and I discussed the frustration the private sector hospitals encounter when attempting to transfer the veterans who have no third party payment source or inadequate insurance coverage. I was asked why other hospital social work directors or social workers do not call or write more often regarding these problems.

I personally started to call Senator Graham's staff person in Tallahassee a few times after the experience detailed above. This staff person obviously remembered my calls and asked if I would be willing to testify . After agreeing to share my views on this subject, I contacted my counterparts in several other Central Florida area hospitals. None of these hospitals gather concise statistics that relate just to the veteran who does not obtain transfer into the VA system when such a request is made. Most of these statistics are lumped into a general financial category. However, all hospital social work directors who were contacted were in agreement that the Florida VA system is extremely difficult to access in most situations that involve veterans who are non-service connected. Many times even service connected veterans are not transferred if bed space is tight, and if the service connected disability does not properly relate to the primary diagnosis.

Senator and distinguished committee members. I have presented to you a common example of the problems a small acute care community hospital experiences in relation to the veteran in need of VA hospital transfer. In the past six months my statistics show that three veterans who had never used the VA system were transferred after much time consuming effort on my part; the part of the veteran's family, and the dedication of a few physicians who cared. At least four veterans and maybe more did not receive such a transfer.

You might be wondering why these veterans did not have another insurance payment source. That perhaps is a whole issue in itself. However, the three transferred veterans were employed in positions where no group insurance was offered . The price of a private insurance policy is prohibitive; and as is often the case, the coverage is inadequate.

South Seminole Community Hospital's statistics might appear insignificant. However, multiply these statistics by the number of acute care private sector hospitals in the State of Florida. That number should give a fair representation of the number of veterans who do not receive access from these type of facilities.

Why do persons in positions such as myself fail to speak out? I cannot answer for others in my profession. However, I do know how much time was spent to make three transfers happen; time that involved the extreme effort of myself, the families of veterans, and South Seminole Community Hospital's physicians. Desired results were achieved only after enlisting the assistance of congressional action. What happens to the veteran in the state of Florida who does not have such people advocating on his or her behalf? It is hard to believe that a system that was supposedly designed to be of assistance to the veteran in need often leaves many with a bitter, frustrating experience.

The Florida veteran deserves much better. The Florida veteran deserves a VA system that is adequately funded to meet the real needs of the veteran population in our State.

I thank you for this opportunity to share these experiences and opinions. I would be happy to answer any questions you may have.

COUNTY VETERANS SERVICE OFFICERS' ASSOCIATION
OF FLORIDA

March 23, 1989

Senate Committee on Veterans Affairs
Room 414
Russell Senate Office Building
Washington, D.C. 20515

ATT: Sandi Isaacson

I wish to take this opportunity to thank Senator Bob Graham and the Senate Veterans Affairs Committee for inviting the County Veterans Service Officers' Association, State of Florida, to comment on the Veterans Health Care System as it pertains to our veterans today.

I'm sure we could discuss many problems at length without being in agreement on the majority of items regarding the provisions of treatment whether or not the veterans are service-connected.

Congress should not vote benefits to veterans or increase their eligibility for medical care without sufficient resources to finance these changes. The resources should follow the concentration of veterans that will be using them, i.e. Florida has restricted resources yet is inundated with many more veterans eligible for medical care than other parts of the country. To maintain sufficient funds in the appropriate areas of the country, there should be a separate committee to study the best sites for clinics and hospitals to be constructed as well as areas that need to be closed or reduced in terms of provision of services rendered. The procedure followed for reallocation of military bases should be followed for VA Health Care facilities.

On this same vein is the turn-over of personnel due to lack of competetive salaries in comparison with the private sector. As it now stands, the VA is simply a training ground, losing good, qualified people to higher paying positions outside of the Veterans Administration at a consistently rapid pace.

I would like to take a second to talk about eligibility, believing that we all understand the criteria and the problems this entails. The ELIGIBILITY CLERK should make the determination and not a doctor, nurse, or other clerk. When a veteran has been approved for treatment by the Eligibility Clerk, then he/she should be treated without question about eligibility in the doctor's office. The categories MAY or MUST be seen should not exist or even be discussed with the veteran when he reports to a medical facility. This is one problem that I have encountered at various medical facilities.

Veterans with PTSD, who are suicidal or homicidal and sent by court order or through emergency care from private hospitals, are being subjected to professionals who tell them that they are just in the hospital trying to get a 100% service-connected disability rating for PTSD. The professionals dealing with these veterans should not concern themselves with anything but treatment. The American Psychiatric Association has recently published the TRAUMA OF WAR: STRESS AND RECOVERY IN VIETNAM VETERANS. The diagnostic chapter shows that many misdiagnoses are given PTSD veterans, separating their problems under many other psychiatric disorders, which is wrong. The professionals at VA Medical Facilities who are concerned that these veterans should not be given ratings at 100% are following this technique to show that the PTSD problem is only a percentage of the veterans' psychological problems and are therefore reducing the rating for PTSD. Accuracy of diagnosis should be the aim of the professional rather than efforts to adjudicate the veterans' claims.

Cutting off Veterans Benefits when it is shown that a veteran missed his evaluation physical only because the hospital or clinic failed to notify the veteran of his appointment is wrong. The VA says it is sorry but the LAW states that if you don't show, you are cut. The veteran should be reinstated with another appointment set up as soon as the error is discovered.

Emergency room procedures need to be evaluated. In Volusia County, the nearest VA Medical Facility is 100 miles away, and if an individual covers that distance, he should be given a thorough examination before being released with a statement that nothing is wrong. I do not know of any veterans willing to drive that far for no reason. Recently one of our veterans died the morning after being sent home without treatment.

Too many VA physicians, when evaluating an individual, make comments that never appear on the medical records. The veteran re-calls the doctor telling him that he should be rated higher or that the condition is related, but no entries to that effect are entered in the charts or medical reports.

Agent Orange veterans have many problems, whether psychological or medical problems with skin disorders. Doctors seem reluctant to write a diagnosis on their evaluation charts.

Specialized physicians should conduct evaluation examinations completely and thoroughly, even if it takes a longer time frame. Often, claims must be refiled because conditions were not considered during the physical that should have been a routine part of the examination. This problem results in added workloads and expense both for the VA and the County Service Officers in processing paperwork. All too often, a veteran relates that his exam was conducted in a manner that did not allow him to discuss any of his medical complaints and that consultations were nearly nonexistant.

Veterans that are admitted to a civilian hospital have difficulty getting the VA notified within the 72 hour time limit because the social worker, doctors, or nurses do not understand the importance of this matter or do not care. Once the VA is notified, then all at once the veteran is better and he is discharged to go home. This is not always the case but it happens all too often and places a financial burden on the veteran and his family. I do not feel a veteran should be punished for the negligence of a hospital's staff, he should be given the benefit of the doubt. A possible solution would be to take steps, by law, to place monetary responsibility/liability on the treating facility which fails to cooperate.

There should be changes made to reward veterans for being rehabilitated. Presently, the system encourages veterans to remain sick for fear their disability compensation will be taken away if they attempt to find employment and gradually work toward being self-sufficient. This probably could be remedied if, once a disability is given, it is made permanent or the veteran may be given a lump sum. The idea that a veteran lives in constant threat of having his income removed causes great concern and interferes with the quality of care of patients, particularly in the psychiatric area.

Nursing home care and adult congregate living facilities, ACLF's, need to be discussed. The medical care service picture has changed over the years because of diagnostic regulations, DRG's. Since Medicare will not pay for long-term hospitalization under diagnosis on admission, people who do not heal quickly (our elderly and those with complicated multiple medical conditions) are sent to nursing homes. More care is required in nursing homes now than in the past due to this shift of responsibility. Adult congregate living facilities are, in turn, now becoming the nursing homes of a few years ago, and consequently, accepting people who require assistance with daily self-care activities, mobility, and reminders on doses of medication. Medicare does not cover ACLF's in the same category as nursing homes.

Many veterans who are eligible for nursing home care, which includes listing room and board as unreimbursed medical expenses, choose to enter an ACLF instead. The law should be changed to allow the VA to consider these same expenses when care is provided by an ACLF. In those cases where the patient's condition allows some latitude and the option is taken for an ACLF, the VA should not penalize the individual for the choice of a more comfortable atmosphere by disallowing expenses for room and board.

More emphasis should be placed on treating our veterans at other places than hospitals and nursing homes. To help the situation, we need to use more hospital or clinic based home care, allowing the veterans to stay at home. In addition, programs at clinics and at hospitals such as the Adult Day Health Care Program would help to keep patients at home and yet be cared for during the daytime. This would be especially valuable for patients that would be so sick as to be borderline nursing home care patients and yet have a supportive family at home. The adult day health care would provide a better quality of life and would offer some relief for the families. The veterans and their families would be happier and the cost would be less. This needs to be explored more and more with our aging population.

Veterans, particularly with emotional disorders, are given 100% for a period of hospitalization and then overpaid because the proper paperwork is not acted on in a timely manner by the V.A. when the veteran is discharged from the hospital. Then the veteran is asked to repay the overpayment and this often causes great hardship.

Suggest since psychotic episodes are allowed a period of convalescence, then PTSD and other emotional disorders also be allowed this period of convalescence.

Transfer to V.A. hospital when physically ill can be done when stablized. However, emotionally ill patients cannot be Baker Acted into V.A. programs and must want to go willingly. Especially with PTSD veterans who have a lack of trust of the government and governmental agencies is this working a hardship. The patient may be in such a state that they cannot be released back to society, but are stablized in a sense that they could go to the

V.A., but their mental illness prevents them from being willing to go. Under such circumstances, they should not be considered stablized or they should be able to be Baker Acted into V.A.

Older veterans who have extreme health care needs which reduce them to poverty level do not have access to the V.A. system unless they can be paid for needing Aid and Attendance. Once the V.A. starts giving medical care and paying for medicines, the veteran is no longer eligible for the monetary benefits of Aid and Attendance and may even end up owing the government money. Some care needs to be given older veterans who have other medical care needs the V.A. may not be able to assist them with which they do need money for. The V.A. could manage medications which are essential for these older veterans who need Aid and Attendance, even if they do not come under the income level to the point of being eligible for Aid and Attendance with their recurring UME's. By the year's end, most of them would even if the V.A. provided necessary medications such as heart medicine, insulin, stroke medication, oxygen and other life essential medications taken by chronically ill patients. This would ease the strain on the last few years of life they have left and show them their country appreciated the sacrifices they made.

In making specific funding recommendations for the various functions of the V.A. Outpatient Clinics, the independent budget would give the individual directors at the V.A. Outpatient Clinics the opportunity to defend their budget submission at the V.A. level. Currently, outpatient clinics' budgets are approved by the V.A. Satellite Medical Centers that have the responsibility to oversee the clinics. The V.A. Outpatient Clinics budget is normally tied in with the parent V.A. Medical Center and gets watered down through the process.

The V.A. hires competent directors, therefore, I feel their budget should be submitted independently and defended by the V.A. Outpatient Clinic Director. He is the individual responsible for the day-to-day operations of the clinic and he is responsible for providing service to the veterans and their dependents in his service area.

A few items of major concern not directly related to health care need consideration in the VA Hierarchy are as follows:

1. Checks are issued by the Veterans Administration without any indication of the check's purpose, i.e. Clothing Allowance, Retroactive Benefits, A&A, Regular Compensation, Improved Pension. It is very confusing to the veteran when he receives a sum of money with no explanation for its purpose. The veteran often brings the check to our offices creating the necessity of a phone call to the VA to verify the monetary award taking up time for counselors at both ends of the line.

2. Severance pay issued to medically discharged veterans is recouped in full by the VA when a disability rating is made for VA compensation. The monies are withheld until the full amount has been paid back. The injustice occurs when the VA recoups the entire amount of Severancy Pay awarded to the veteran not taking into consideration that taxes are paid on this sum. VA benefits are not taxable and it is unfair to charge the veteran's account to repay money that was paid to the IRS.

Statement of

Donald B. Thompson, Director

Southeast Region, Veterans Health Services & Research Administration

Before the

Senate Committee on Veterans Affairs

United States Senate

March 23, 1989

Mr. Chairman and Members of the Committee

I am pleased to have the opportunity to discuss the Department of Veterans Affairs provision of health services to entitled and eligible veterans in Florida.

The Veterans Health Services and Research Administration provides health programs to eligible veterans in Florida through a network of five medical centers comprising Medical District 12. These medical centers are at Bay Pines, Gainesville, Lake City, Miami, and Tampa. In addition, ambulatory health services are provided at clinics located in Daytona Beach, Ft. Myers, Jacksonville, Key West, Oakland Park, Orlando, Pasco County, and Riviera Beach. In addition, a clinic in Pensacola serves veterans from the northwest Florida Panhandle under the auspices of Medical District 10.

The veteran population of Florida is now an estimated 1,484,169 veterans. Currently there are 2916 hospital beds authorized, complimented by 840 nursing home care beds and 200 domiciliary beds. The combined medical center employment ceiling is 9015.2 FTEE and the aggregated FY 1989 budget is over $479,555,196.

The workloads of the facilities providing care to Florida veterans have grown steadily over the past twenty years. The Medical District Initiated Program Planning projections indicate continued population growth through 1995 with dramatic increases in veterans 65-74 years of age, while during the same years veteran population is decreasing in the nation as a whole. Due to the increasing average age of Florida veterans, their population is expected to peak around the year 2000 at 1,519,900 veterans then decline through the year 2010. This means that our plans must address the needs of rapidly aging veterans, the preservation of acute services they will require, as well as the longer-term services generally recognized as needed, involving nursing home beds, and the development of non-institutional innovations such as adult day care centers, hospital based home care, residential care and the like to offset the needs for inpatient bed services. Implementation of our planning initiatives in the last four years has been essentially limited to re-direction of resources within the region, moving them from lower to higher priority of need.

Significant improvements have been made in the budgets of Florida medical centers. In Fiscal Year 1974, shortly after the passage of legislation establishing ambulatory care entitlement, the combined budgets of the five medical centers totaled $110,180,187. By Fiscal Year 1980, at the height of veteran migration into the state, the medical center budgets had grown to

$239,432,460, more than double the 1974 figure. During this same period, the outpatient clinics came into being and significant construction and activation funding was provided. Beginning with Fiscal Year 1984 and full implementation of our Resource Allocation Methodology, and continuing to the current year, the combined budget has risen from $353.2 million in FY 1984, to $384.9 in FY 1985, to $409.8 in FY 1986, to $418.8 in FY 1987, to $462.6 in FY 1988, and finally to $479.6 million in FY 1989, a doubling of the FY 1980 figure. The percentage of growth of the Florida medical center budgets clearly has been greater than the percentage of growth of the total medical care budget. This does not, however, mean that funding is adequate to meet the needs of all entitled and eligible veterans now living in the state.

During hearings before the Senate Committee on Veterans Affairs, which were conducted in Washington on September 9, 1988, I testified to budgetary shortfalls in the Southeast Region approximating $80 million. Roughly 25 percent of that shortfall, or $20 million was identified in Florida facilities. These shortfalls were created by an erosion of the recurring bases of the medical centers due to insufficient funding for inflation cost increases, to repeated absorptions of unfunded personnel costs; to consecutive application of one-percent productivity based reductions; to absorption of costs of increased entitlements and administrative requirements which were unfunded when legislation was passed. These shortages have caused medical center Directors to divert their equipment and maintenance and repair funds to purchase needed medical supplies and services, and to deplete shelf stocks in order to maintain levels of workload necessary to address their local demand for care. Our FY 89 funding allocation, although the largest we have ever had, simply cannot offset these shortfalls and, indeed, is insufficient for our medical centers to attain the level of services provided in Fiscal year 1988.

The funding increases that Florida medical centers have received came from the general medical care budget, principally through activation of clinics mentioned previously and through our Resource Allocation Methodology. The Chief Medical Director, with the Fiscal Year 1989 budget, established a policy of equity of access and distributed funds on the basis of priority of workload, specifically fixing the allocations to the percentages of discretionary and non-discretionary workloads. The percentages experienced by the Southeast Region were set as the target levels for the remaining six regions. This meant that significant numbers of lower priority category veterans, whose care is not mandated by law and subject to the availability of space and resources, would have to be excluded from future care. Because of the then wide variance between regions in terms of low priority access, the effected regions were given three years to reduce their discretionary workloads to our level of 1.5 percent for inpatient care and 8.3 percent for outpatient care.

The Southeast Region was given more than $5 million as a result of a data validation process in the Resource Allocation Methodology. This, together with our earnings under the RAM productivity application, put this region much closer to parity with other regions. I, in turn, distributed funds available to me on the same basis; that is, medical centers with higher than average non-discretionary workloads received relatively more funding than facilities with higher than average discretionary workloads.

The effect of the budget shortfall on the availability of VA health care to individual veterans is significant. Medical centers in Florida, as well as all other areas of the country, are being forced to curtail services to Category B and C veterans. Admissions criteria for both hospitalization and outpatient services are being more stringently applied. Certain specialty clinics are being discontinued if the veterans previously served by them can be adequately treated in other, more general clinics. The combination of insufficient funding resources and staff shortages, particularly in nursing services and certain technologist and technician categories, have caused directors to temporarily close wards or treatment units in order to consolidate and concentrate patients into more efficient units of care. This is particularly true in instances where occupancy rates on given wards were below optimum.

Further, reduced staffing is creating longer waiting times as veterans are cued into the rationed system. This is particularly a factor in those specialty areas in which our physician salaries are not competitive and vacancies exist for extended periods of time. We are increasingly being forced to rely upon contracts to acquire the physician and other specialty coverages which cost our medical centers much more for each equivalent person than it costs to maintain staff at current salary limits.

The quality of health care services currently available through our health care facilities in Florida is high. It is, however, being rationed to assure that funds are available for maintaining that quality for the veterans who enter into treatment. Inpatient facilities are mal-distributed in that Lake City and Gainesville are within 45 miles and Tampa and Bay Pines within approximately 35 miles of one another. This results in adequate bed levels for the primary service areas immediately surrounding those facilities but leaves large areas of the state with heavy population density underserved for inpatient care. Florida has the third lowest beds per 1000 veterans in the country. Current planning calls for a 400-bed general medical and surgical hospital at West Palm Beach to be constructed beginning in Fiscal Year 1990 and a 470-bed general medical and surgical hospital to be designed for East Central Florida also beginning in FY 1990. Psychiatric needs will be partially met by a planned 200-bed addition at Gainesville to meet a critical shortage of long-term and acute beds. Units have been activated to provide psychiatric care at Miami, Bay Pines, Lake City and Dublin, Georgia. Each planned new facility will also have psychiatry beds to meet the remaining projected needs. Future additional bed needs were identified for the Lee County area and for Okaloosa County in the Panhandle. These latter two projects are not currently authorized. Attainment of these plans would move Florida to approximately the national average of beds per 1000 veterans.

A serious threat to the quality of our inpatient services is the diversion of needed equipment and maintenance dollars previously mentioned. Quality is not an average value. If it were, a quality program would be either the best of the worst or worst of the best. If our equipment and technological level is allowed continues to deteriorate, we will be unable to maintain the current high quality of care delivered. Radiographic equipment that is not maintained on line will reduce quality, regardless of how many physicians or nurses are on the staff and available to care for the patient.

Outpatient care is of excellent quality in Florida and, with a total of one million, 256 thousand visits, our market penetration per 1000 veterans exceeds many other areas of the country. However, access to care on the part of veterans without service-connected conditions and for who are not otherwise mandated, is severely limited. The veteran population of Florida contains a higher percentage of service-connected veterans than does the rest of the country as a whole. That, plus the density of population surrounding our facilities, caused our workloads to rapidly exceed funded levels making it necessary to impose stringent controls to contain growth. Category B and C patients are experiencing scheduling restrictions and certain specialty clinics, even for Category A veterans, are experiencing delays. A recurring complaint heard at all of our medical centers is that veterans coming into Florida are provided less services than the veteran was accustomed to receiving in his home state.

Nursing Home care in Florida is currently provided by either 120-bed or 240-bed units at each existing medical center. A 240-bed unit, originally envisioned at the West Palm Beach facility was deleted from planning but space on the site is reserved for a future unit should demographic data warrant such a unit in the future. Other units are tentatively planned for East Central Florida, Orlando, Fort Myers, and the future medical centers when they are developed. In the interim, extensive use is made of the Community Nursing Home Program consistent with market share and bed sizing guidance.

Development and activation of the planned facilities will only partially meet the future needs of Florida veterans. The inadequacy of activations funding and the erosion of recurring operating funds must be addressed if we are to provide for the needs of those veterans with the highest priority claim to VA care. As the aging veteran experiences more health problems and as the costs of care continues to escalate in non-VA sectors, the veteran is likely to turn to the VA for his care. The priority categories are sufficiently broad that the demand for care will likely exceed our funded capabilities.

In summary, the recurring funding base for Florida health care facilities has been eroded and care is being rationed, restricting free access to that care. This erosion has reduced the dollars available at a time when demand for our services is growing. We cannot continue to maintain current service levels with the dollars available and reductions in workloads are the only acceptable means of attaining funds from our current allocations to maintain the quality of our care.

TESTIMONY OF MALCOM RANDALL

MEDICAL DISTRICT DIRECTOR, MEDICAL DISTRICT 12 (FLORIDA)

AT THE HEARING OF THE SENATE COMMITTEE ON VETERANS AFFAIRS

ORLANDO, FLORIDA

MARCH 23, 1989

I am pleased to appear before this hearing of the Senate Committee on Veterans Affairs, particularly since it is being chaired by Senator Bob Graham who has done so much for the veterans of Florida. I will file my written statement with the committee and will present a short summary of the statement.

Medical District 12 is essentially Florida, with the exception of eight counties in the Panhandle which are a part of Medical District 10 and the addition of 19 counties of South Georgia. The veteran population in Florida increased 43.3 percent between 1970 and and 1980, while the veteran population nationwide increased only 3.8 percent. The Florida veteran population is projected to increase another 12.5 percent between 1980 and 1995, when it will reach 1,519,900. During this same period, the veteran population nationwide is projected to decrease 9.7 percent.

The basis of planning intiatives in Medical District 12 via the Medical District Initiated Planning Process (MEDIPP) has been to increase VA health care resources comparable to national levels of availability. Since the establishment of MEDIPP in 1981, there has been some shift of resources to Florida. For example, new VA outpatient clinics have been established at Daytona Beach, Pensacola, Port Richey, and a small VA presence with the Navy in Key West. An additional VA clinic is planned for Tallahassee, scheduled for activation in 1991.

Currently, Medical District 12 has the third lowest number of VA hospital beds per 1,000 veterans among the 27 Medical Districts (1.9 versus 2.8 nationally). A 1982 congressionally mandated "Thirty Year Study of the Needs of Veterans in Florida" documented the need for 1,483 additional VA hospital beds in Florida by the year 2000. A 1983 followup study sited four new hospitals in Florida (in priority order--Palm Beach, Brevard, Okaloosa, and Lee Counties). A 400-bed hospital is scheduled for construction in Palm Beach County in 1990, and construction of a 470-bed hospital in East Central Florida is planned for 1983.

Medical District 12 has the lowest number of total psychiatry beds per 1,000 veterans of any District in the nation and has essentially no long-term psychiatry beds. Because of the critical need for long-term psychiatry beds, this year a few acute psychiatry beds at Bay Pines and Miami were redesignated for extended psychiatric care. However, this problem will not be adequately addressed until the proposed 200 additional long-term psychiatry beds are constructed at VAMC Gainesville as a District resource. The need for these beds was first identified more than 15 years ago and continues to be the number one construction priority in the Medical District plans.

An addiitional high priority construction need, the number two priority in the Medical District plans, is the planned clinical addition/SCI addition project at Tampa. This project has continued to slip, and construction is now scheduled for FY 1992.

The budget shortfall in the Veterans Administration has had a significant impact on medical centers in Florida. Major operational changes have been implemented that impact on both the inpatient and outpatient programs. The operational changes have been made so that the fiscal integrity of the facilities can be preserved in light of the budget shortfall in the Veterans Administration.

The rapidly expanding outpatient programs at the medical centers and outpatient clinics in Florida have placed heavy strains on the budgets of VA medical centers. During the past five years, changes in medical practice have shifted workloads from inpatient hospital care to the outpatient setting. One result of this shift has been dramatic increases in outpatient workloads, putting pressure on already limited resources. Between FY 1984 and FY 1988, the number of outpatient visits in Medical

District 12, excluding Pensacola, increased from 876,929 to 1,159,185. During this same period, new outpatient clinics were brought on line in Daytona Beach and in Pasco County. Resource limitations have not permitted facilties to increase services commensurate with demand. The outpatient workload in Medical District 12 facilities would have grown significantly more if not restrained due to resource limitations.

In FY 1989, all VA medical centers have had to reduce the number of veterans that receive primary health care. One facility has curtailed the scheduling of all Category C veterans for the ambulatory care program. At another facility, outpatient care has been restricted to Category A veterans. Category B and C veterans receive counseling on eligibility, are clinically evaluated, and then referred to community resources. This same facility has implemented a policy that drops veterans from the outpatient program who have missed two scheduled appointments. Nonservice-connected veterans who need chronic, continuing care are being dropped from the rolls, or not picked up initially, even though community resources might not be available to care for them. This selective disenfranchisement of certain patients considered discretionary from health eligibility has caused serious concerns with the physician staff. Physicians are voicing concern about their ability to provide ethical primary care with this scheme of rationed health care. Continuing this practice of rationed health care may lead to the physician staff leaving VA employment if they are forced to withdraw treatment from chronically ill patients in this fashion. Many veterans moving to Florida have received continuing medical care at the VA where they were previously enrolled. It is extremely difficult for a physician to explain to a veteran the reason they can no longer receive VA health care in Florida.

One positive thing for Florida that has come out of the national budget shortfall has been the decision by the Chief Medical Director that "equity of access" is to be a factor in the system for the distribution of funds to the individual VA medical centers. Since the Southeastern Region had the lowest levels of discretionary workload (8.3 percent for outpatients and 1.5 percent for inpatients), these figures were to serve as the base line for the country. Any medical center with a higher discretionary workload than these figures would have funds that equated to their non-discretionary workload withdrawn until their level of discretionary workload was the same as the Southeast. These funds were to be shifted to those VA medical centers with low discretionary workload levels over a three-year period. Florida hospitals have not yet felt the effect of this re-distribution. Many of the VA medical centers around the country had funds withdrawn, but that money was used to help meet VA's national budget shortfall rather than transferring the money to those hospitals with the low discretionary rate.

In summary, we have made progress in getting new construction for Florida and in opening new outpatient clinics. However, the recurring funding base for Florida hospitals has been eroded over a period of years as a result of absorption of increased costs I have previously mentioned. Coupled with this is the unprecedented demand for care brought about by the massive movement of veterans to Florida. As a result, the Florida medical centers cannot continue to provide current services with the dollars available to them.

STATEMENT OF
STATE COMMANDER WILLIAM FABREGAS
BEFORE SENATOR ROBERT GRAHAM
VETERANS AFFAIRS COMMITTEE OF THE U.S. SENATE
SITTING IN ORLANDO, FLORIDA
MARCH 23, 1989.

On behalf of the more than 87,000 members of Florida's Disabled American Veterans and it's Ladies Auxiliary, I would like to take this opportunity to present our general views on the issue of Veterans Health Care and our specific views regarding access to the VA Health Care Facilities in the State of Florida.

As our National Commander Mr. Kirby recently pointed out to a joint session of the House and Senate Veterans Affairs committee, this country faces an acknowledge crisis in the area of federal health care.

In Florida, the issue of a veterans' health care crisis is not something that we can look forward to, it is a fact that has been faced by this state's veterans for the past 10 to 15 years. This fact was recently brought to light by a killing in a VA parking lot, it happened because the veteran had no place to go nor any resource to turn to.

Florida is the place to retire, thousands of individuals move to Florida each month and most of these individuals are in the category of 'senior citizens'. At a time when the demand for skilled medical care, including nursing home care, is most needed, the VA is forced to close nursing home beds, recently 30 beds in the Gainesville VA Medical Center have been closed because of a lack of financial resources.

The State of Florida has not established any State veterans home or state nursing home to house or provide care for these homeless veterans.

Congress has mandated that veterans rated 50% or more, because of service connected disabilities, are entitled to medical treatment for any condition, except dental. Yet veterans who are rated totally and permanently disabled are being denied needed medicine and medical treatment because monthly dollars limits are being placed on medicine and treatment programs.

As you know, a state domiciliary is now under construction and in the near future will be excepting applications for admission. This will help but, more federal funding will be needed to assist the state in building additional domiciliary and nursing home units.

Florida, with the exception of the counties located in the panhandle area of the state, are in the VA's 12th Medical District. With the migration of veterans to the area served by the 12th District are not adequate to meet the current needs of our veterans population, let alone the needs of those veterans who are "winter residents" of the state.

A recent survey conducted by the U.S. House of Representatives showed by the VA's own account that it would take an additional $45 million dollars and an additional 1,600 personnel to bring the VA health care employment level equal with the staffing this additional funding were to take place, it would only accommodate current work load levels. It would not meet the total needs of Florida's current or future veterans.

As you know, Florida has the oldest veterans population in the nation. The veterans' median age in Florida is 57 years old. Florida also has the most severely disabled veterans in the country according to the VA. These VA statistics show that 63.79% of all VA outpatient care in Florida was for conditions directly related to a veterans' military service while 46% was the nation wide average.

While these statistics do not provide all the answers, they clearly indicate that Florida is not receiving it's fair share of federal VA resources and more importantly, that Florida veterans do not have the same access to VA treatment as veterans in other areas of the country have.

Given the older and more disabled veterans population of Florida, more and longer term health care is required.

Florida ranks 42nd among all the states with VA hospital beds available at the rate of 1.9 beds per thousand veterans. Massachusetts, for example, has almost one half as many veterans residents as Florida but slightly more VA hospital beds (2795 beds in Florida compared to 2893 beds in Massachusetts). This gives the veteran in Massachusetts twice the chance of receiving treatment as the veteran in Florida has.

Hardly a day goes by when a veteran does not stop by our headquarters which is located 15 miles from the Gainesville VA Medical Center and state that he was unable to have his health care needs met.

However, let me state that it is not the fault of the Gainesville VA Medical Center. They and the other VA facilities in Florida are doing an excellent job with the resources they have available to them. The problem is they do not have enough resources to meet the demand for services. Several examples have been documented and the individual veterans letters are attached:

1. A monthly limit has been placed on the dollar value of medicine that a 100% service connected veteran can receive on a fee basis.

2. A monthly limit has been placed on the amount the VA will pay for fee basis surgery.

3. VA's refusal to provide drugs which were prescribed by its own physicians.
4. Delays in scheduling required doctors appointments; examples:

   a. 8 months to get an eye appointment.

b. 3 months to get a cardio vascular examination.

These are but a few of the concerns that veterans express at our headquarters office, we could document hundreds more, but those cited serve to illustrate the severity of the problem.

While I could go on and on about individual veterans needs in terms of medical care, in the interest of time, let me summarize by simply stating "adequate VA health care resources are not being provided to Florida's veterans". Our veterans are being short changed by anywhere from $45 million (by the VA's own estimate) to $160 million per year (estimate by State Department of Veterans Affairs). This is not acceptable to Florida's veterans and the DAV strongly believes that immediate action must be taken by the Florida delegation to correct this situation.

What can be done to improve this situation?

1. First and foremost, Senator Graham, you should introduce and work for the passage of legislation that would return 3rd party payments and other funds received by the VA back to the facility that provides the service. It currently goes to the Treasury general fund and is not available to the facility that provided the service.

2. Expedite the building of the Palm Beach VA Medical Center.

3. Introduce and work to past legislation that will allow dollars to flow to where the work is being accomplished. Currently Florida facilities are sending prescriptions to the northern regions of the country to these patients who winter in Florida.

4. Insure that federal funds are available for State Domiciliary and nursing home construction and operation.

5. Finally and most important, work to increase the VA health care budget so that all VA facilities including Florida's will have adequate funds to accomplish their mission.

In summary, the facts are that the 1.5 million Florida veterans do not have adequate VA health care resources available. Therefore, their access to VA health care facilities is being severely limited. In fact, hundreds of veterans are being denied needed health care.

Senator, we desperately need your and the entire Florida congressional delegation's help to correct the severe crisis we face in VA health care in Florida.

Lets remember to adequately care for those who have served this great nation of ours.
Remember "America is #1 thanks to it's veterans".

Thank you for allowing me to appear and give testimony on this very important issue.

STATEMENT OF

NATIONAL DIRECTOR WAYNE HITCHCOCK. PAST DEPT. CMDR.

AMERICAN EX-PRISONERS OF WAR

BEFORE THE

U. S. SENATE COMMITTEE ON VETERANS' AFFAIRS

MARCH 23, 1989

ORLANDO, FLORIDA

Senator Graham. on behalf of the members of the American Ex-Prisoners of War we wish to thank you for holding these hearings.

I am Wayne Hitchcock with the American Ex-Prisoners of War, now serving as a National Director of the Southeast Region and the immediate Past Commander of The Department of Florida.

We do not have with us this date a prepared statement so will forward such to you in the immediate future. We do however, concur with those statements given this day by the other veteran organizations. The majority of our organization, I am certain are also members of one or more of those veteran groups.

There is however one item we would like to address that does pertain solely to The Former Prisoner of War. I am referring to a section contained in the recent Public Law #100-322. We would like to thank you for the role you played in this law becoming a reality, especially that of your introduction of Senate Bill #9 which was incorporated into the final bill. In Public Law 100-322 under the section reading PRIORTY FOR OUTPATIENT CARE requires that the Administrator SHALL furnish such medical services as needed to: (1) any veteran for service-connected disability; (2) any veteran with a service-connected disability of 50% or more for any disability; (3) any veteran disability as a result of VA treatment or in pursuit of vocational rehabilation. PL 100-322 further requires outpatient medical services necessary in preparation for or to alleviate the need for hospital admission for any disability to: (1) any veteran with a service connected disability rating of 30% or 40%; and (2) any veteran whose annual income does not exceed the maximum annual rate of non-service connected pension disability. Thirdly, the Administrator MAY furnish medical services to veterans in the following priority order. (1) any veteran who has a service-connected disability of less than 30% or any veteran for a compensation or pension examination; (2) FORMER PRISONERS OF WAR and veterans with eligibility based on exposure to toxic substances; (3) veterans of the Mexican border period or World War I whose annual income exceeds the maximum annual rate of pension; and (4) veterans in receipt of increased pension or compensation based on the need of regular aid and attendance.

The American Ex-Prisoners of War served their country not only as veterans who experienced combat at its worst, but were called on to continue serving as prisoners. Many times delaying or hindering plans of the enemy, and allowing our troops to gain important ground. These men and women endured extreme hardships as prisoners of war and now suffer from the effects of many diseases, malnitrution and exposure.

Therefore, we, The American Ex-Prisoners of War see the need and request that the section regarding OutPatient Care in PL 100-322 be changed and we be placed in the first catagory under the part that reads SHALL BE TREATED.

We ask for your support in this important matter.

PROPOSED STATEMENT OF HULAN M. SULLIVAN, SUPERVISOR
FLORIDA DEPARTMENT OF VETERANS' AFFAIRS
FIELD OFFICE
VAMC, BAY PINES, FLORIDA
BEFORE THE COMMITTEE OF VETERANS' AFFAIRS, UNITED STATES SENATE
March 23, 1989

Mr. Chairman, and members of the Committee:

The Florida Department of Veterans' Affairs is very appreciative for this opportunity to express its concern regarding the 1989 budget shortfall and administration - proposed budget for fiscal year 1990.

The Florida Department of Veterans' Affairs maintains an office and a staff of 5 full-time employees located on the grounds at the Veterans Administration Medical Center, Bay Pines, Florida. During the first four months of this fiscal year that office conducted no less than 5,116 personal interviews with the hospital in-patients and other veterans seeking the assistance of our office in obtaining health care. I mention this only as a means to point out our high veterans advocate profile role which we play. This role brings us into a daily contact not only with the veterans seeking care from this facility, but those persons mandated to provide that care. Through this daily contact we have drawn conclusions which we feel are valid and will be discussed here today.

The VAMC Bay Pines Administrator and his staff, are to be commended for their unrelenting gallant efforts to maintain the Center's commitment to high medical standards in the delivery of health care to the veterans in its catchment area.

Gentlemen, the budgetary problems faced by this group are very significant and I do not feel they can be resolved without the additional funding.

The identified 1989 budget shortfall for this Center is 12.4 million dollars. The effects of this shortfall in the budget appear to be concentrated into several areas which I shall now discuss.

Pharmarcy, at the beginning of this fiscal year the pharmacy service was under funded in the amount required to meet its operating needs. That service has requested an additional $975,000 to get through the remainder of this fiscal year. The Bay Pines Center does not have the funds to support that request. As a temporary measure, the center has requested and received permission to transfer $300,000 from the third quarter to the second quarter of this year. Thus, when they enter the third quarter, they will still have the $600,000 deficit to deal with.

What are the solutions proposed to deal with this problem? Many options were proposed and considered, although as of yet, none have been implemented. As an example of determining the merit of various options considered to overcome these shortfalls, two of these are discussed. There was a recommendation made to reduce the community home workload. This means in effect that a freeze will be placed on the funds originally set aside to provide contract care in non-VA facilities for those veterans who have reached maximum hospitalization at this facility. This will in effect, place a greater financial burden on those veterans and families least able to absorb the nursing home cost. Experience has shown that a majority of these veterans involved are category A patients. Not only will this have an impact upon the veterans which I have just described, it will also have an affect upon the diagnoses related group (DRG's) and the ability of the hospital to remain within the parameters.

An other option considered was to freeze other control points (that is a freeze on funds budgeted for particular services or programs.) Those services or programs considered for this freeze are yet to be identified. However, one must conclude that any freeze to any existing service or program will have a demonstrable effect upon benefits received by our veterans.

The second problem area to discuss is the effects of the 1989 budget shortfall upon personnel staffing at this facility.

First, it is important to note the medical center does not have the authority to reduce patient workloads or to reduce spending for employees below its personnel services floor.

As we sit here today, that facility has funding in its personnel services floor to support 1,987.4 FTEE. They have a total of 30 full time employee positions they cannot support with their budget.

This facility is also experiencing great difficulty in recruiting personnel to meet the needs throughout the medical center. At the present time their need list includes a total of 348.65 FTEE's "supportable." Of this total, they estimate the most critical needs to be 150 full time employees. I asked what this meant in terms of dollars - they indicated that the average salary and benefits for the employee they were seeking was $35,000. This equates to a total cost of $5,250,000.

At this point I asked where the medical center was hurting most personnel wise and why? The response I received was the largest impact had been identified in support areas such as clerical support, technicians, building management, dietetics and engineering. Significant deficiencies exist in these areas because of a hiring freeze; the high turnover rate which they normally experience in addition to cuts in employees as a result of the budget shortfall.

My next follow on question was what impact had this had or will have on the ability to provide quality and timely health care to the Bay Pines patients? They indicated that the inability to fill the technical positions and clerical positions in patient care areas resulted in delays in diagnoses and treatment of patients. They also indicated that due to these shortages in the non-professional staff that Registered Nurses were required to take on additional non-nursing duties such as performing EKG's; transcribing orders/processing order entry into computer; cleaning beds/mopping floors for spills; struggling to get lab reports done during off hours; transport drugs to outlying buildings; transport patients on off-tours; and exercising activities on the unit (no PT or CT). They also indicated they had a period whereby they restricted admissions to a medical services ward based on the limited staffing configuration. They foresee into the future that there may be an interruption in their cardiology program as well, because of the anticipated vacancies. Their vascular surgery program was interrupted in this fiscal year because of staffing gaps as were their phychiatry services. They further indicate that their particular situation may be further stressed due to seasonal fluctuations in demand because of the popularity of Florida during the winter months, and that it is not uncommon to have a high census in their specialty care units such as the CCU and the SICU.

On the administrative side of the operations they also indicate that the shortage of personnel has impacted on the capacity of the support services to function efficiently. There is evidence of increasing stress and burnout among the lower grade employees which is indicated by an increase in their utilization of sick leave. The timeliness of administrative processes such as admitting office screening, filing of medical records documents, processing of patient records following discharge and retrieval of those records when the veteran appears for health care has greatly impacted the ability of those sections to provide timely services. This equates to a longer waiting period for those veterans seeking evaluation or admittance to this facility.

The VAMC at Bay Pines also is a "clinic of jurisdiction". There is a great management concern over this particular program since it is a mandated program which supports our Non-VA activites. The program is designed to service the needs of the service connected veterans who have service connected emergencies in the community and are unable to access a VA facility. Management is predicting a serious shortfall in this program. The projcted shortfall is over $540,000 for this fiscal year.

The Center's discretionary/non discretionary workload has been identified as of February 18, 1989, as 6.1 percent for discretionary out-patient visits (Bay Pines & Fort Myers), and 1.31% discretionary discharges.

The above figures show that of the 4,765 patients discharged from Bay Pines as February 18, 1989, 98.65 percent were veterans receiving mandated care. During the same period, 93.9 percent of the 84,301 receiving outpatient care were patients mandated by law. These figures reflect that this hospital's workload is essentially dedicated to providing mandated health care.

I ask this panel to consider the past budgets for the medicare and medicaid programs. If in fact this review was made, I would predict that such a comparison would show the budget for those two programs would be ever increasing while the budget for the Veterans Administration's Department of Medicine and Surgery budget would remain relatively flat. You may ask why is this relevant? Relevancy exists because this hospital must shop in the same marketplace to recruit quality people, buy supplies and equipment and material. This drives up the cost of that material far beyond their budget capabilities.

I hold great respect for the medical center Director and his staff and their diligent efforts to deal with the center's $12.4 million budget shortfall. I personally feel without additional funding for this and the upcoming fiscal year, that their efforts will be in vain. I see a very predictable course which will lower the current standards for quality and timely health care benefits to our veterans. The shortfall will most effect the mandated health care benefits since this facility is essentially already dedicating their total efforts to treating the mandated health care veteran.

Mr. Chairman, this concludes my statement.